

Stenhouse

95th Congress }
1st Session }

COMMITTEE PRINT

{ COMMITTEE
PRINT 95-22 }

HOSPITAL COST CONTAINMENT

PREPARED BY THE STAFF

FOR THE USE OF THE

SUBCOMMITTEE ON

HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND

FOREIGN COMMERCE

U.S. HOUSE OF REPRESENTATIVES

WITH THE ASSISTANCE OF THE CONGRESSIONAL RESEARCH
SERVICE, LIBRARY OF CONGRESS



SEPTEMBER 1977

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1977

94-076

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HARLEY O. STAGGERS, West Virginia, *Chairman*

JOHN E. MOSS, California
JOHN D. DINGELL, Michigan
PAUL G. ROGERS, Florida
LIONEL VAN DEERLIN, California
FRED B. ROONEY, Pennsylvania
JOHN M. MURPHY, New York
DAVID E. SATTERFIELD III, Virginia
BOB ECKHARDT, Texas
RICHARDSON PREYER, North Carolina
CHARLES J. CARNEY, Ohio
RALPH H. METCALFE, Illinois
JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
ROBERT (BOB) KRUEGER, Texas
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
JIM SANTINI, Nevada
ANDREW MAGUIRE, New Jersey
MARTY RUSSO, Illinois
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BOB GAMMAGE, Texas
ALBERT GORE, Jr., Tennessee
BARBARA A. MIKULSKI, Maryland

SAMUEL L. DEVINE, Ohio
JAMES T. BROYHILL, North Carolina
TIM LEE CARTER, Kentucky
CLARENCE J. BROWN, Ohio
JOE SKUBITZ, Kansas
JAMES M. COLLINS, Texas
LOUIS FREY, Jr., Florida
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
W. HENSON MOORE, Louisiana
DAVE STOCKMAN, Michigan
MARC L. MARKS, Pennsylvania

W. E. WILLAMSON, *Chief Clerk and Staff Director*

KENNETH J. PAINTER, *First Assistant Clerk*

ELEANOR A. DINKINS, *Assistant Clerk*

FRANK W. MAHON, *Printing Editor*

PROFESSIONAL STAFF

ELIZABETH HARRISON
JEFFREY H. SCHWARTZ
BRIAN R. MOIR
KAREN F. NELSON
ROSS D. AIN

CHRISTOPHER E. DUNNE
WILLIAM M. KITZMILLER
MARK J. RAABE
THOMAS M. RYAN
RICHARD LINDSAY

ROBERT HENLEY LAMB, *Associate Minority Counsel*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

PAUL G. ROGERS, Florida, *Chairman*

DAVID E. SATTERFIELD III, Virginia
RICHARDSON PREYER, North Carolina
JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
JAMES J. FLORIO, New Jersey
ANDREW MAGUIRE, New Jersey
EDWARD J. MARKEY, Massachusetts
RICHARD L. OTTINGER, New York
DOUG WALGREN, Pennsylvania
HARLEY O. STAGGERS, West Virginia
(*Ex Officio*)

TIM LEE CARTER, Kentucky
JAMES T. BROYHILL, North Carolina
EDWARD R. MADIGAN, Illinois
JOE SKUBITZ, Kansas
SAMUEL L. DEVINE, Ohio (*Ex Officio*)

STEPHAN E. LAWTON, *Counsel*

ROBERT W. MAHER, *Director of Research and Planning*

JO ANNE GLISSON, *Senior Staff Associate*

DONALD K. DALRYMPLE, *Assistant Counsel*

STEPHEN J. CONNOLLY, *Senior Staff Associate*

BURKE ZIMMERMAN, *Research Assistant*

ROBERT CRANE, *Staff Associate*

WILLIAM CORR, *Assistant Counsel*

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

CONTENTS

	Page
I. Background: The problem.....	1
II. General summary.....	8
Administration approach.....	8
Cost estimates, H.R. 6575.....	12
Alternate approach.....	13
III. Issues for subcommittee discussion.....	15
Issues related to Title I.....	15
A. Start and duration of program.....	15
B. Institutions subject to proposed revenue limits.....	16
C. Nature of limitations on revenue increases.....	17
D. Application of revenue limits.....	20
E. Exemption of nonsupervisory personnel wage increases from revenue limit.....	21
F. Exceptions to the revenue limit.....	22
G. Exemption for hospitals in certain States.....	24
H. Improper changes in admissions practices.....	25
I. Enforcement provisions.....	26
J. Disclosure of information and review of determinations..	27
K. Additional issues.....	28
Issues related to title II—Limitation on capital expenditures.....	30
Additional issues relating to discontinuance of unneeded hospital service.....	37
IV. Expenditure and other financial data for community hospitals.....	44
Data on hospital expenditures.....	45
Hospital utilization data.....	50
Factors in increasing hospital costs.....	53
Hospital capital data.....	57

HOSPITAL COST CONTAINMENT

I. BACKGROUND: THE PROBLEM

During the past 25 years, national health expenditures have increased not only in aggregate terms and on a per capita basis but also as a percentage of the gross national product. In 1950, national health expenditures amounted to \$12 billion, or 4.5 percent of the GNP. Preliminary estimates for fiscal year 1976 indicate that health expenditures amounted to \$139.3 billion, or 8.6 percent of the gross national product. Expenditures for hospital care are the largest component of national health expenditures, reaching an estimated \$55.4 billion in fiscal year 1976 (or about 40 percent of total expenditures).

Expenditures for hospital care have risen annually at double-digit rates for a decade. During fiscal year 1965, the year prior to enactment of medicare and medicaid, expenditures for hospital care amounted to nearly \$13.2 billion. Within 5 years, the annual outlay had almost doubled to \$25.9 billion, and by fiscal year 1976, expenditures had more than quadrupled to \$55.4 billion. The average annual increase from 1965 to 1976 was 13.9 percent; adjusted to reflect constant prices in the general economy, the average annual increase was still 8.6 percent. The following table presents the annual increases in hospital care expenditures since fiscal year 1950.

TABLE 1.—EXPENDITURES FOR HOSPITAL CARE, SELECTED FISCAL YEARS 1950-76

	Total expenditures (billions)	Annual percent increase
Fiscal year:		
1950	\$3.7	-----
1955	5.7	9.0
1960	8.5	8.4
1965	13.2	9.1
1970	25.9	14.5
1971	29.1	12.3
1972	32.7	12.4
1973	36.2	10.7
1974	41.0	13.3
1975	48.2	17.6
1976	55.4	14.9

The growth in hospital care expenditures has been financed largely through increases in health insurance benefits and increases in public program expenditures for hospital care, most notably medicare and medicaid. By 1976, these sources paid 90 percent of the Nation's hospital bill, with private health insurance paying an estimated 35 percent and public programs paying 55 percent. Direct payments by patients accounted for less than 9 percent.

Two general measures are available for quantifying hospital price and cost inflation—American Hospital Association measures of cost per day and per admission, and Consumer Price Index measures.

The American Hospital Association measures of average expense per patient day and per admission are derived by dividing total hospital expenses by the number of days of care or the number of admissions. Adjustments are then made to account for the volume of outpatient care provided, yielding measures of expense per adjusted patient day and expense per adjusted admission. A summary of these measures since 1965 is as follows:

TABLE 2.—COMMUNITY HOSPITAL EXPENSES PER ADJUSTED PATIENT DAY AND PER ADJUSTED ADMISSION
1965-75

	Expense per adjusted patient day	Expense per adjusted admission
1965-----	\$40.56	\$310.79
1966-----	43.66	337.54
1967-----	49.46	409.04
1968-----	55.80	471.30
1969-----	64.26	539.25
1970-----	73.73	610.10
1971-----	83.43	675.01
1972-----	94.87	749.47
1973-----	102.44	799.03
1974-----	113.55	885.69
1975-----	133.81	1,026.79

The Bureau of Labor Statistics has developed a number of medical care components of the Consumer Price Index. One is the hospital semiprivate room charge index, which measures charges for room, board, and routine nursing care in hospitals. A more refined measure developed in the early 1970's is the hospital service charge index, which is a weighted average of separate charges for room, board, operating room, and eight specific services.

Examination of the Consumer Price Index measures since 1960 shows that hospital charges have increased at faster rates than prices in general except during the economic stabilization program. Table 3 summarizes the average annual increases in the various components of the Consumer Price Index. Note that for the period April 1974 to December 1976, after the wage and price controls of the economic stabilization program were lifted, hospital costs increased at an annual rate nearly twice that for prices in the economy in general. Latest available data indicate that for the first 4 months of 1977, hospital, service charges continue to increase at rates faster than prices in general. Between January and April 1977, the hospital service charge index increased at a rate 28 percent faster than the Consumer Price Index.

TABLE 3.—ANNUAL RATES OF INCREASE IN CONSUMER PRICE INDEX AND SELECTED MEDICAL CARE COMPONENTS,
SELECTED PERIODS, 1960-76

	Fiscal 1960-66	Fiscal 1966-71	Economic stabilization program August 1971 to April 1974	Post controls period April 1974 to December 1976
CPI, all items-----	1.4	4.5	6.4	7.5
CPI, all services-----	2.2	6.0	5.1	8.9
Medical care, total-----	2.6	6.5	4.3	11.0
Medical care services-----	3.2	7.7	4.9	11.6
Hospital service charge-----	(¹)	(¹)	² 4.6	13.4
Semiprivate room charge-----	6.0	14.6	5.7	15.4

¹ Not available.

² Annualized rate of change computed from January 1972, rather than August 1971.

A number of explanations have been offered for the intense and sustained inflationary trends in hospital costs over the years. For example, it has been argued that spiraling costs are attributable to increases in the demand for hospital care, and to the response by hospitals to this demand. Because private insurers and public third-party payments (for example, medicare and medicaid) finance the overwhelming proportion of the care rendered in community hospitals, the actual net costs of care for most patients at the time of hospitalization are very small. The patient and his agent, the physician, therefore, can elect the most expensive (and, presumably, the best) care available—more expensive than they might elect if the third-party payment programs did not exist. Comprehensive prepayment enables hospitals to provide more amenities, more technology, more staff, et cetera—the very inputs which drive up the costs of hospital care. In short, the facilities can greatly increase the costs of care without significantly increasing the direct financial burden on patients. This process may even be self-reinforcing: The high cost of care creates pressures for even more comprehensive third-party protection and the expanded coverage, in turn, enables hospitals to produce ever more costly care.

Another explanation of the nature and origin of hospital inflation focuses attention on the methods currently used to reimburse or pay hospitals for care rendered patients under third-party programs. Hospitals are reimbursed according to either the costs they incur in delivering patient care or the prices or charges they assign for different units of service they supply to patients. The predominant method of reimbursement, used by medicare and medicaid, and most Blue Cross plans, is cost-based reimbursement. Cost reimbursement involves determinations, in accordance with established cost principles, of the actual costs incurred by the facility in the rendering of patient care. Payments are made at periodic intervals based on estimated operating costs with retroactive adjustments made for each accounting period.

This retrospective cost-based reimbursement mechanism has come under increasing criticism in recent years and has been cited as one of the contributors to the inflation in health care costs. Specifically, this method of paying for hospital care is viewed as inflationary: (1) Because it fails to set effective limits on the costs to be reimbursed; and (2) because it fails to offer incentives for efficient performance or, alternatively, to create disincentives for inefficient operation. It has been observed that most cost-based systems contribute to hospital inefficiency and wasteful expenditures (and, thereby, to hospital inflation), because such systems virtually guarantee payment for costs that (a) are not determined in the usual competitive marketplace, (b) are virtually unregulated by public authority, and (c) are not effectively controlled by the facilities themselves. It is also argued that cost-based reimbursement contains disincentives to contain costs, since any reductions in cost only result in reduced income to hospitals from third parties which pay on a cost-basis.

Reimbursing institutions on the basis of charges, or the prices established by them for different hospital services, has also been criticized. Charges for certain services may be entirely unrelated to the actual costs of producing such services. Cost increases are easily countered by changes in the charge structure of an institution. There are often

few, if any, external pressures (including pressure from third parties that pay on a charge-basis) on facilities to economize or resist cost increases in their operations.

Still another explanation for hospital inflation attributes escalating costs to uncontrolled capital expenditures and certain advances in medical technology. Hospitals in a single community often duplicate highly specialized and expensive services and equipment. Idle capacity is expensive because its overall costs are spread among fewer users, and because it may create pressures to provide excessive or unnecessary services. Advances in medical technology have made it possible to treat patients with an array of high-cost therapies (for example, cobalt therapy, renal dialysis equipment), not previously available. These advances are costly for a variety of reasons. The capital acquisitions are themselves costly, and they require specialized personnel to staff new equipment and services.

Increasing labor costs have also been cited as a source of hospital cost inflation. It has been noted that hospitals are employing larger and larger numbers of personnel to produce services for patients, and that wages for such personnel have increased at rates above those received by other workers in the economy as a whole. In addition, there appear to be few opportunities for improved productivity in a highly labor intensive industry, such as the hospital industry, for new capital investment in the hospital frequently does not lead to a reduction in the hospital labor force. On the contrary, such investment often requires the hiring of even more hospital employees.

Though there is no single, overall explanation of hospital inflation, each of the aforementioned theories has contributed to a partial understanding of the cost control issue. Some of these theories, as well as a number of others, have also provided theoretical bases for previous efforts to moderate or limit hospital costs. Major examples of past and current efforts to limit hospital cost increases follow in the discussion below.

ECONOMIC STABILIZATION PROGRAM

The economic stabilization program (ESP) established a series of economy wide wage and price controls which were designed to reduce inflation by about one-half in the economy as a whole. The program began with a freeze on wages and prices in August 1971—phase I. The freeze was replaced in December 1971 with control programs for each major sector of the economy—phase II—including health.

For the health care industry, phase II consisted of a ceiling of 6 percent per year—adjusted for changes in volume of services—on increases in price and revenues per inpatient day for institutional providers of health care such as hospitals. Within the overall 6-percent ceiling, a 1.7-percent increase in expenditures for new technology was provided. In addition, separate ceilings were applied to wage-related expenses—5.5 percent—and to nonwage expenses—2.5 percent. Non-institutional providers, such as physicians and dentists, were allowed a 2.5-percent increase per year in their prices. The effect of the phase II controls was approximately a 50-percent decline in increases in hospital room and board rates and a 25-percent decline in cost per adjusted patient day and cost per adjusted admission.

Phase III, which lasted from January 11 to June 13, 1973, was an extension of phase II for many areas of the economy, including the health care industry. On June 13, 1973, another freeze on the prices of all commodities and services began and lasted until July 1, 1973, when it was superseded by phase IV. Phase IV covered many industries including health until April 30, 1974, when ESP authority expired and the program ended.

The goals of the hospital controls under phase IV as expressed by then President Nixon were to reduce the excessive rate of increase in the cost of hospital stays; to moderate increases in new services and selectively control capital expenditures; to provide economic incentives for the substitution of less expensive ambulatory care for inpatient hospital care; to provide for the development of State, rather than Federal, administration of health care controls; to allow internal flexibility and incentives for health care managers to improve productivity; and to be responsive to cost-saving innovations, such as health maintenance organizations.

For the health care industry, phase IV included:

A limitation of 7.5 percent on increases in hospital charges and costs per inpatient admission, with adjustments for volume of services.

A 6-percent increase limit on outpatient charges per procedure.

A 4-percent increase limit on medical practitioners' aggregate annual fees, with a 10-percent increase limit for individual fees over \$10 and a \$1 increase limit for fees under \$10.

A 6.5-percent increase limit for long-term care institutions on average realized revenues per day by class of purchaser (for example, medicare, medicaid, all other) or level of care (for example, skilled nursing care, or existing levels by State or by institutions).

The phase IV controls differed from phase II in their emphasis on the total cost of a hospital stay, also called an admission, rather than the individual price per day. In addition, phase IV treated separately increased costs due to new and approved capital expenditures and separated controls on inpatient and outpatient services.

Before ESP went into effect, the annualized rates of increase in prices of medical care and of hospital charges (semiprivate room) exceeded that of prices in the economy as a whole. During the various phases of ESP (August 1971 to April 1974), not only were the rates of increase for medical care and hospital charges reduced, but the rates of increase dropped below prices in the economy as a whole. In the post-ESP period, after the controls were lifted, the rates of increase for medical care and hospital charges rose above the pre-ESP levels and once again exceed prices in the economy as a whole (see table 3). This temporary effect in lowering prices is due in part to the fact that ESP was a cost-containment program which did not attempt to address the underlying problems in the process of health care delivery, some of which are the unusual system of supply and demand where the users of health care usually pay only a small portion of the costs they incur; the maldistribution of manpower; and the high costs of medical and technological advances.

HOSPITAL REIMBURSEMENT LIMITS UNDER MEDICARE AND MEDICAID

The 1972 amendments to the Social Security Act authorized the Secretary of HEW to establish prospective limits on the costs to be reimbursed under the medicare program. The Secretary was given broad discretion in the selection of the institutions and kinds of costs to which the limits are applied and in the method of setting the limits.

Under present policy, costs limits are established each year for the routine cost portion of hospital costs—essentially, the cost related to bed and board. Individual hospitals are assigned to one of various groups, depending on the hospital's size and the per capita income of the area where it is located. The cost limit for hospitals in each group is set by a formula that establishes the limit high enough to permit the routine costs of well over 80 percent of the hospitals to be covered in full.

In fiscal year 1975, the first full year of implementation, approximately 345 hospitals were reported to be in excess of the limit by a total of \$36 million. Fiscal year 1976 data are not yet complete, but thus far 334 hospitals have been reported to be in excess of the limit; it is expected the total will increase above the fiscal year 1975 number when all reports are in.

The objective of the costs-limits provision is to establish ceilings that reasonably prudent and cost-conscious hospitals can be expected to live within. And by setting the limits in advance, it was intended that high-cost hospitals could, if they wished, undertake the cost reduction measures to avoid loss of reimbursement. Where a hospital exceeds the limit and wishes to make up the lost income by imposing a special charge on the patients, the patients must be advised of the situation in advance.

The 1972 legislation also authorized medicare, medicaid, and the maternal and child health program to withhold reimbursement from hospitals for certain capital expenditures for plant, property or equipment if the designated planning agency has determined them to be inconsistent with State or local health facility planning requirements. The reimbursement amounts that may be withheld include depreciation, interest on borrowed funds and other costs related to capital expenditures. Where a proprietary hospital is involved, the return on equity capital is also affected. The provision applies only to expenditures that exceed \$100,000, that would change the bed capacity, or that would substantially change the services offered by the hospital unless the State chooses to give the provision wider applicability.

FEDERAL EXPERIMENTATION AND STATE PROGRAMS

The Social Security Administration is conducting a range of research and experimental activities relating to reimbursement and is attempting to control costs under experimental authorities included in the Social Security Amendments of 1967 and 1972, and section 1526 of the National Health Planning and Resources Development Act of 1974. The 1972 amendments authorized a broad program of experimentation in prospective reimbursement and other alternative reimbursement and ratesetting methods.

Under its authority, the Social Security Administration evaluated State and local systems which were already operating without Federal funding, and began supporting demonstrations, evaluations, and developmental projects in other States.

Three principal prospective reimbursement methodologies have been identified, which are generally used in some combination:

Budget review approach, involving setting or approval of reimbursement rates based on a detailed review of the projected budgets of individual hospitals and their departments. This approach is used in Maryland in its ratesetting, and is used in New Jersey and Connecticut in combination with a formula approach. Budget review is also done by exception, involving review only of those institutions whose entire budget, or portions of that institution's budget, exceed established screens.

Formula methods, involving the use of formulas to determine rates of payment, or to determine ceilings or target rates under current reimbursement practices. New York uses a formula approach, and other States use this approach in combination with the other methods.

Negotiated rates, involving joint decisionmaking by the hospital and the ratesetter. Rhode Island and the Rochester, New York area use a negotiated budget methodology called "Maxicap" in which a total community budget for hospital care is set through use of negotiation and application of an inflation formula. The hospitals then negotiate with the rate setters under the restraints of the "cap."

The Social Security Administration has identified five elements which it believes are essential in a prospective rate setting system:

- (1) All hospitals within a given system should submit accounting and reporting data based on uniform systems.
- (2) Health planning and ratesetting should be closely coordinated.
- (3) Prospective ratesetting systems should focus on total hospital expenditures including utilization factors.
- (4) Prospective ratesetting systems should cover all payors.
- (5) Hospital participation in prospective ratesetting systems should be mandatory.

In addition to evaluations of ongoing activities, the Social Security Administration is funding a number of demonstration and developmental activities to gather further information on ratesetting systems.

A recent American Hospital Association survey identified 25 rate regulation programs, including several Blue Cross prospective reimbursement plans. Budget review was the principal method used but often in combination with other methods. A total of 2,070 hospitals and 1,407 nursing homes participated in the programs surveyed. In addition to the 25 programs currently in effect, the survey identified 13 States as contemplating some form of program.

II. GENERAL SUMMARY

ADMINISTRATION APPROACH

General discussion

Permanent, long-range reforms are needed to address the complex issues underlying health care cost inflation. Over the long-run, the behavior of those directly responsible for the delivery of health services, as well as those of the people who use, pay for, monitor and regulate health care services, must be changed. It is widely recognized that reimbursement systems which are based on retrospective payment of costs are inefficient and costly. While long range reforms are clearly needed, it is generally agreed that fundamental changes will take several years to fully develop and implement. In the meantime, however, costs continue to increase at such high rates that some transitional action is necessary while long-term systems are being developed and put in place.

One of the reasons for developing an immediate system to slow the increases in health care costs is that rising health care costs have hampered the ability of Federal and State governments to meet other pressing social problems. For example, between 1966 and 1978, the HEW health budget increased from \$3.0 billion to \$44.5 billion. Of this increase, \$37.3 billion has gone to pay for benefits under Medicare and Medicaid, with only \$4.2 billion left over for expansion of other governmental health activities beyond their 1966 level. The rapid increases in hospital costs have played havoc with State budgets, and have made it necessary for many States to make serious cuts in ambulatory care services under Medicaid. Additionally, private health insurance premiums have jumped 20-30 percent in the last year, cutting into most workers' take-home pay. Americans today must work more than one full month of every year just to pay for their health care. It takes about 2 weeks' wages to cover hospital costs alone. Higher health insurance premiums paid for fully or in part by employers drain off money that could be provided to workers in the form of higher wage increases or pension benefits.

For these reasons, an effective transitional program to control costs is necessary. A basic requirement for any system which will be effective over the short-run is that it be administratively simple, and that it can be implemented without significant expansions of information requirements or of staff at either the Federal or State level. Since satisfactory systems for classifying hospitals and comparing cost performance are only being developed, a flat cap on increases in costs represents a more immediately workable control system. In order to assure effective control, it is argued that variations from the Federal program can be allowed only in States where a system of demonstrated effectiveness is operating, where there is assurance that the program will be as stringent as the Federal system, and where excess payments can be recovered if the limits are exceeded.

It is generally recognized that long-term control of health care costs must address the issue of capital development in the health system. Steps can be taken now to slow the growth of capital expenditures by health care institutions. To complement this long-term approach, and assure that savings are realized by health care consumers and payors, controls on increases in revenues collected are also necessary.

It is argued that we cannot forego dealing with spiraling health care costs pending the development of complex permanent reforms or during the longer period that will be required to influence attitudes toward the health care delivery system on the part of providers and consumers of health services. As a first step toward bringing about efficiency and economy in the Nation's health care system, hospitals can be induced by statute, financial incentives, and public pressures to behave differently. These transitional measures can begin to alter long-standing hospital cost patterns and will serve as a basis for the development of more refined, permanent reforms in the methods of paying for health care services.

H.R. 6575

The bill is divided into two titles. Title I would establish a transitional hospital cost-containment program to constrain the rate of increase in acute-care hospital inpatient costs by limiting the amount of inpatient revenues which hospitals may receive from each source of payment for patient care. Title II would set an annual limit on hospital capital expenditures and would require the Secretary of Health, Education, and Welfare to establish a ceiling on the supply of hospital beds and a standard of occupancy of hospital beds as criteria for approval of such expenditures.

TITLE I

Beginning October 1, 1977, about 6,000 acute-care and specialty hospitals would be subject to a limit on increases in their revenues from inpatient services. This revenue increase limit would apply to increases in payments by each third-party cost payer (for example, medicare, medicaid, and Blue Cross) and to increases in charges to control revenue from private health insurance companies and individuals who pay their own bills.

Application of limit.—Under cost containment, the rate of increase in each hospital's inpatient revenues from average charges imposed or costs paid by each government or nongovernment cost payer would be limited to a fixed percentage of such revenues in the hospital's base year, generally its accounting year ending in 1976. This percentage would reflect the currently established revenue limit in effect under the bill, plus any limits in effect during prior cost-containment periods, including any applicable adjustments or exceptions. The limit would also reflect an adjustment to account for hospital cost increases between the end of the hospital's base year and October 1, 1977, the effective date of cost containment. This adjustment would be calculated to allow an average annual rate of increase in hospital costs during the interim period equal to the average annual increase in the hospital's inpatient costs during the base year and the preceding accounting year. The interim period adjustment would be at an average annual rate of not less than 6 nor more than 15 percent.

In order to keep total inpatient revenues within the established limits, the allowable increase in revenue per admission would be calculated on the basis of estimated changes in each hospital's admissions.

The estimated limit per stay would be applied to interim reimbursement, subject to adjustment as necessary at final settlement following the close of the fiscal year. Holding charges per admission within the limits would be the responsibility of the hospital subject to retrospective verification by the medicare intermediary.

Basic limit.—Each year, the Secretary would promulgate a basic limit on increases in inpatient hospital revenues to be effective in the following Federal fiscal year. The basic limit would be set by a formula designed to reflect general price trends in the economy, as measured by the "GNP deflator," and to accommodate some increase in the intensity of inpatient services, that is, one-third of the difference between the increase in the GNP deflator and the average annual increase in hospital costs in the 2 preceding years.

For fiscal year 1978, the formula would result in a basic limit of about 9 percent, a rate 50 percent greater than the estimated 6-percent increase in the GNP deflator. In future years, as hospital cost-containment efforts narrowed the gap between increases in general prices and increases in hospital costs, the basic limit would more closely approximate the rate of increase in the GNP deflator.

The bill includes provisions for certain adjustments and exceptions to the basic limit on inpatient hospital revenue increases.

Patient-load adjustment.—The basic limit would be adjusted for changes in a hospital's patient load only if its admissions since the base accounting year had increased by more than 2 percent or decreased by more than 6 percent (10 percent in the case of small hospitals—those with fewer than 4,000 admissions per year). Increases or decreases in admissions outside these limits would result in allowable revenue increases or decreases, respectively, at the rate of one-half of average revenue per admission. For large hospitals, an additional allowance for admission increases or decreases in excess of 15 percent would require an exception.

Nonsupervisory wage increase adjustment.—The revenue increase limits otherwise applicable could, at the hospital's option, also be adjusted to reflect wage increases at a higher rate for a hospital's nonsupervisory employees.

Exceptions to the limit.—The Secretary would have authority to grant exceptions to the limits otherwise applicable in certain cases where a hospital's admissions had changed by more than 15 percent or where the hospital had undertaken major changes in facilities or services, provided that the changes were found to be appropriate by the State health planning and development agency and the hospital could also demonstrate a relatively poor financial position. Any hospital granted an exception would be subject to an operational review of its effectiveness and efficiency by the HEW Audit Agency, whose report would be made public.

Hospital exemptions.—The Secretary would have authority to exempt from the provisions of the bill hospitals in States that have a hospital cost-containment program which is at least as strict as the

Federal guidelines and meets certain other conditions. The Secretary could also exempt a hospital whose exclusion is determined to be necessary to facilitate the conduct of an experiment or demonstration project.

Disclosure.—Hospitals would be required to make available for dissemination to the public certain information, including current charge schedules and cost-reimbursement reports.

Enforcement.—Reimbursement above the cost-containment limits would be disallowed under medicare and medicaid. Excess revenues paid by any other cost payer or received by a hospital would be subject to a 150-percent tax on both the hospital and the payer. A similar tax on excess charge revenue would be imposed on the hospital unless the hospital placed the excess amount in escrow until it had incurred a shortfall in allowable charge revenue equal to the amount of the excess.

The Secretary could exclude from participation in medicare and medicaid a hospital which alters its admission practices to avoid the effect of the limits.

Duration of program.—The transitional hospital cost-containment program would be effective until permanent reforms in the delivery and financing of health care became effective. The Secretary would be required to submit his recommendations for permanent reforms to the Congress by March 1, 1978.

TITLE II

Capital expenditures limit.—Hospital capital expenditures would be subject to a national limit in the aggregate of \$2.5 billion per year, apportioned among the States initially on the basis of population, and subsequently on the basis of population and other variables such as differences among the States in construction costs, need for hospital construction or modernization, and other factors which will assure equitable apportionment.

Capital expenditure would be defined as an expense not for operation and maintenance which changes a hospital's bed capacity, substantially changes its services, or exceeds \$100,000, including the cost of studies, surveys, plans, working drawings, specifications, and other related activities.

Hospital beds supply ceiling and occupancy standard.—The Secretary would be required to promulgate a national supply ceiling on hospital beds not to exceed 4 beds per 1,000 population, and a national standard rate of hospital bed occupancy of not less than 80 percent.

Enforcement.—States would be prohibited from issuing certificates of need approving hospital capital expenditures in excess of the State's capital expenditures limit or for an increase in hospital beds in a health service area whose bed capacity exceeded or occupancy rate fell below the established standards.

In a State which had not established an approved certificate of need program, medicare and medicaid reimbursement to a hospital which undertook a capital expenditure which was not approved by the Secretary would be reduced by 10 times the amount of attributable depreciation, interest, and return on equity capital.

COST ESTIMATES, H.R. 6575

The following table presents the administration's estimates of savings which would result from enactment of the administration proposal.

ESTIMATED SAVINGS UNDER ADMINISTRATION HOSPITAL COST CONTAINMENT BILL EFFECTIVE OCT. 1, 1977

[In millions of dollars]

	reBasic venue limit	Exceptions		Net impac	Net savings in Federal hospitals ²
		Wage pass- through	Capital projects		
Fiscal year 1979:					
Total ³	-7,610	+2,115	+600	-4,895	-550
Medicare.....	-2,505	+695	+175	-1,635	
Medicaid—Federal.....	-345	+95	+30	-220	
Fiscal year 1980:					
Total ³	-12,620	+3,390	+1,035	-8,195	-920
Medicare.....	-4,265	+1,125	+325	-2,815	
Medicaid—Federal.....	-570	+155	+50	-365	
Fiscal year 1981:					
Total ³	-18,770	+4,795	+1,600	-12,375	-1,360
Medicare.....	-6,525	+1,605	+510	-4,410	
Medicaid—Federal.....	-845	+220	+75	-570	
Fiscal year 1982:					
Total ³	-25,670	+6,320	+2,330	-17,020	-1,860
Medicare.....	-9,135	+2,140	+765	-6,230	
Medicaid—Federal.....	-1,145	+290	+110	-745	

¹ Contains all admission adjustments.² Assuming Federal hospitals conform to the guidelines of the hospital cost containment bill.³ Includes savings in both public and private spending in non-Federal hospitals only.

Source: Social Security Administration/Office of the Actuary (R. Harris), July 25, 1977.

It should be noted that the Administration has estimated savings occurring under title I of the bill only. Although title II would result in independent savings if title I was not enacted, the joint impact of both titles is such that they estimate no separate or additional cost impact of title II, because of the impact of the title I limits. However, the Congressional Budget Office has prepared estimates of the cost impact of the title II program if it stood alone. Two things should be noted: (1) These savings are not additional to savings estimated under title I above, and (2) the cost impact of title II represents savings to the hospitals; without some system to require hospitals to pass the savings on to the consumer, they would not necessarily represent savings to the payors.

ESTIMATED SAVINGS RESULTING FROM ADMINISTRATION'S PROPOSAL TO CONTROL HOSPITAL CAPITAL EXPENDITURES (TITLE II)

[In millions of dollars]

	1978	1979	1980	1981	1982
Savings in capital expenditures ¹	410	1,110	1,840	3,040	4,350
Savings from reduced operating costs ²	370	1,570	3,420	6,420	10,770
Total, anticipated savings.....	780	2,680	5,260	9,460	15,120

¹ Assumes that debt financing accounted for 80 percent of capital expenditures and was amortized as follows: New beds, 25 yr at 8.5-percent interest; other construction, 10 yr at 10-percent interest; equipment, 3 yr at 12-percent interest.

Assumes that hospitals' own assets accounted from 8 percent of capital expenditures that would have been spent in the year the project was completed.

Assumes that outside but not debt financed sources, primarily philanthropy, accounted for 12 percent of capital expenditures and were not part of the hospital's costs.

² Assumes that for each dollar of decrease in total capital expenditures for a particular year, hospital operating costs in subsequent years would be reduced 50 cents. Also assumes that half the capital expenditures in a particular year would result in savings in operating costs that same year.

Source: Congressional Budget Office, June 1977.

ALTERNATE APPROACH

General discussion

Arguments have been made that a hospital cost containment program should be directed towards the encouragement of budget review programs within State governments with the federal role limited to standard-setting and oversight as far as is possible. The arguments for this approach are concerned with three general areas:

1. *Specificity*.—The formula "cap" as applied by the Administration's bill does not take into account variations among hospitals with respect to the level of efficiency already achieved, the need of the community for more, or less, hospital services, or variations in size, case-mix, or location, partly because of the administrative difficulty of doing this in a national program. It has been argued that several states have already demonstrated the ability to develop budget review systems which take these variables into account and these efforts should be encouraged.

2. *Consistency*.—Title XV of the Public Health Service Act (Health Planning), Part B of Title XI of the Social Security Act (Professional Standards Review), and Title II of the Administration's cost containment bill, H.R. 6575, all involve a similar premise. That is, the Federal Government will define standards or limits but the actual regulatory process will be the responsibility of State Governments or local organizations. It is argued that the assumption underlying the entire health regulatory structure to date has been that the health care industry is one which demands local input and interaction if it is to adequately provide for the needs of the population it serves. For this reason, control of operating expenditures would also be at the State level if the State and regional character of health regulation is to be preserved.

3. *Coordination*.—It has also been pointed out that coordination of health planning, utilization review, quality assurance, and budget review is essential if all the factors leading to spiralling health costs are to be attacked. For example, cost containment programs which place major emphasis on lowering the unit cost of hospital services penalize hospitals with low occupancy rates since such hospitals have a high ratio of fixed versus variable costs. In the name of efficiency, this creates incentives to hospitals to increase their volume of services. Although unit costs might indeed go down, the end result could be to increase the total volume of expenditures by those who pay the bills. It has been proposed that this situation could be remedied through appropriate coordination of PSRO and budget review activities. Similarly, stringent cost containment activities may create incentives to skimp on quality of care. Again, coordination of PSRO and budget review mechanisms has been proposed as a mechanism to monitor this problem.

The effects of underutilization on costs has also been put forth as one of many arguments for the need for coordination of health planning activities and cost containment or budget review activities. Cost containment programs will normally attempt to lower the high unit cost of underutilized services. Such revenue restraints may interfere with the ability of any particular institution to provide that service, thereby causing questions of community need and access to arise. For

this reason, it has been proposed that a cost containment program be closely coordinated with the health planning organizations, HSAs and SHPDAs, so that health planning decisions concerning the "appropriateness" of underutilized services be taken into account in deciding what the allowable cost for a unit of hospital service shall be. It has been argued that it may be in the community's interest to pay the higher unit costs in order to assure that a sufficient amount of hospital care is available. The community may also wish to redirect health care resources into other segments of the health care industry and the coordination of planning and budget review is seen as a mechanism with which to accomplish these goals.

H.R. 8687

An alternative approach is proposed by Mr. Carter in H.R. 8687. Under H.R. 8687, the states would have the primary responsibility for initiating cost containment programs with the Federal role limited to oversight and technical assistance. The Federal government would also pay for the start-up costs of state programs.

Federal oversight of state programs would be instituted through imposition of a Federal revenue limit (similar to H.R. 6575) and states would be required to contain the aggregate rate of increase in inpatient hospital revenues at or below the estimated aggregate increase allowed under the Federal program.

States would also be required to institute formal, cooperative agreements between State health planning and development agencies, Professional Standards Review Organizations, and State budget commissions.

The Secretary would be empowered to rescind the state's exemption from the Federal revenue limitation program if the State was not able to conform with these requirements. The Secretary would also be directed to assist those states who were having difficulty complying with the Federal requirements.

In operating a State budget commission, the state would be required to establish a State Commission on Hospital Budgets to prospectively review and approve hospital budgets within the State and an advisory council representing providers, payors, consumers, planners, and PSROs. Other requirements would include uniform definition of costs, use of positive incentives, public disclosure of budgets and conflicts of interest, and the annual submission of budgets and associated volume levels. The choice of a specific budget review methodology would remain with the State.

III. ISSUES FOR SUBCOMMITTEE DISCUSSION

Issues raised for subcommittee discussion are structured around the provisions of the administration bill. These issues are generic in nature and provide a focus for discussion of both the administration plan and alternate approaches.

The administration's proposed Hospital Cost Containment Act of 1977 (H.R. 6575) is divided into two titles. Title I is a transitional program to limit the annual percentage increase in payments for in patient hospital services, with adjustments for changes in the number of admissions. Title II would set an annual ceiling on hospital capital expenditures and would require bed supply and occupancy standards to be met in order for capital expenditures to be approved. The following sections describe the features of the administration proposal, incorporating technical amendments suggested by the Department of Health, Education, and Welfare. Also included is a discussion of issues raised regarding various features of the proposal, and an outline of alternative and additional provisions.

ISSUES RELATED TO TITLE I

A. START AND DURATION OF PROGRAM

Description of issue

The administration bill is designed to take effect on October 1, 1977. All covered hospitals would be subject to the revenue limitations specified in the bill at that point, regardless of the correspondence of the date with an individual hospital's accounting year. The program is designed to continue until permanent reforms are adopted or until legislation is enacted to repeal it. The program established under the bill is intended to be transitional. The bill specifies that by March 1, 1978, the Secretary of HEW must submit a report to Congress setting forth his recommendations for a long-range program intended to replace the transitional requirements set forth by the bill.

Discussion

Although the cost containment program established by the administration's bill is intended to be temporary, the legislation contains no expiration date. The program would continue to be in effect unless it were repealed or otherwise changed by an act of Congress.

In addition, the effective date of the program (October 1, 1977) would not correspond to an individual hospital's accounting year in the case of about 85 percent of the hospitals. Unless a hospital's accounting year began on October 1, the hospital might be subject to two separate revenue limits applied to it during each accounting year under the program.

Alternate or additional proposals

Mr. Rogers offers a proposal which would make the program effective for hospital accounting years beginning after December 31, 1977.

B. INSTITUTIONS SUBJECT TO PROPOSED REVENUE LIMITS

Description of issue

Hospitals subject to the proposed revenue limits number about 6,000 short-term, acute-care, and specialty hospitals. The administration bill excludes from the revenue limitations the following institutions: (1) hospitals receiving at least 75 percent of their revenues from federally defined health maintenance organizations (HMO's) on a capitation basis; (2) Federal hospitals; (3) chronic-care hospitals; that is, hospitals with average durations of stay of more than 30 days; and (4) new hospitals less than 2 years old. The bill also provides that a hospital may be exempted from the revenue limits of the proposal if the Secretary determines that (1) such exclusion is necessary to facilitate an experiment or demonstration entered into under section 402 of the Social Security Amendments of 1967, section 222 of the Social Security Amendments of 1972, or section 1526 of the Public Health Service Act, and (2) the experiment or demonstration is consistent with the purposes of the bill. (The administration's proposal would also exempt from the revenue limitations hospitals in those States which have statewide cost-containment programs that satisfy certain criteria specified in the bill. This particular provision is discussed in detail in another section of this document.)

Discussion

The administration limited the cost-containment program to inpatient services because they represent the most expensive mode of treatment. The exclusion of outpatient costs represents a significant simplification. Also, any incentive to shift patient care from the inpatient to the outpatient setting is desirable so long as quality of care is maintained, since outpatient care is considerably less costly. (However, to prevent hospitals from shifting costs of inpatient services outside the hospital to avoid the revenue limit, the ceiling would exclude from the base any services previously performed in the hospital that were moved out of the hospital.)

The administration has explained that Federal Government hospitals would not specifically be included in the legislation because these facilities already operate under budget constraints—and these constraints would be modified with respect to short-term inpatient units to reflect the objectives of the overall national system and to set an example for the private sector. The exclusion of chronic-care hospitals is justified on the grounds that they do not have the same inflationary problems as acute-care hospitals.

The administration proposes to exempt hospitals dealing predominantly with federally defined HMO's in order to provide incentives for the further development of organizations perceived to be cost-effective and efficient and because HMO's are already subject to cost constraints because of prepayment of premiums. With respect to the exception for experiments, the Department of HEW is conducting a number of research and experimental activities relating to reimbursement and cost control under authorities included in the Social Security Amendments

of 1967 and 1972, and the Public Health Service Act. Under these authorities, a broad program of experimentation in prospective reimbursement and other alternative reimbursement and ratesetting methods is under way. HEW has evaluated States and local ratesetting systems which were operating without Federal funding and began supporting demonstrations, evaluations, and developmental projects in other States.

Alternate or additional proposals

None.

C. NATURE OF LIMITATIONS ON REVENUE INCREASES

Description of issue

Beginning October 1, 1977, and continuing until the controls are terminated, a hospital's average "revenues" per admission would generally be limited to specified percentage increases over its average per admission revenues in its base year. For almost all the hospitals covered by the proposal, the base year would be the hospital's accounting year that ended in 1976.

The limit that would be placed on a hospital's average revenue per admission would be calculated, subject to certain further adjustments, in the following manner:

(A) To accord recognition, within limits, to hospital cost increases that will have taken place between the base year and the October 1, 1977 effective date, the per admission revenue for the hospital's base year would first be increased to the same extent as it would have increased during that period had it risen at the same rate as the hospital experienced during its base year and the preceding accounting year. For example, if the hospital's cost had increased at an average annual rate of 12 percent during its 1976 (base year) and 1975 accounting years, its average revenue per admission figure for the base year would be increased by the same rate for the interim (pre-effective date) period. However, the administration bill sets additional artificial limits on the amount of increase that will be allowed in adjusting the base year up to the effective date of the program. The bill provides that this increase could not exceed an annual rate of more than 15 percent or be less than 6 percent.

(B) The hospital's average revenue per admission would be further increased for each Federal fiscal year the proposed controls are in effect. Before the October 1 beginning date of the Federal fiscal year, the Secretary of HEW would calculate the percentage of allowable further increase by adding:

(i) the rate of increase in the implicit price deflator of the GNP (Gross National Product) for the 12-month period ending the previous June 30; and

(ii) one third of the difference between the average annual rate of increase in the GNP deflator for the 2 previous calendar years and the average annual rate of increase in total hospital expenditures during the same period.

For example, in calculating the allowable increase for a fiscal year, assume the GNP deflator was five percent for the 12-month period ending with the previous June, and that for the 24-month period ending

the previous December, the GNP deflator increased at an average annual rate of 5 percent and hospital expenditures increased 14 percent. In this case, the allowable increase would be 8 percent—that is, 5 percent plus one-third the difference between 5 percent and 14 percent,

If the GNP deflator for a fiscal year exceeds by more than one percentage point the figure used in calculating the revenue limit for that year, the revenue limit would be adjusted upward to the appropriate degree. (The adjustment would not apply to hospital accounting years that ended prior to the calendar quarter in which the adjustment was made.)

(C) The revenue limit for a hospital, as calculated above, would be further adjusted to take account of changes in its patient load if its admissions had increased since the base accounting year by more than 2 percent or decreased by more than 6 percent (decreased by more than 10 percent in the case of small hospitals—those with fewer than 4,000 admissions in its base year). Increases or decreases in admissions outside these limits would result in allowable revenue increases or decreases, respectively, generally at the rate of one-half of the average revenue per admission. For large hospitals, an additional allowance for admission increases or decreases in excess of 15 percent would require an exception.

Discussion

The annual revenue limit contained in the administration bill is designed to take into account general price trends in the economy (measured by the “GNP deflator”) and increases in the intensity of inpatient hospital services (one-third of the difference between the increases in the GNP deflator and the average annual increases in hospital cost during the 2 preceding years). For fiscal year 1978, these factors in the formula produce a basic limit of slightly less than 9 percent, a rate almost 50 percent greater than the estimated 6-percent increase in the GNP deflator. The formula is constructed in such a way, however, that in future years the gap between increases in general price levels and increases in hospital costs will narrow. As a result, the revenue limit would decline over time (see following chart).

ESTIMATED INPATIENT HOSPITAL REVENUE INCREASE LIMIT

[In percent]

	Assumed price deflator	Hospital revenue increase limit
Fiscal year:		
1978.....	6.1	8.7
1979.....	6.2	9.3
1980.....	5.4	7.6
1981.....	5.0	7.1
1982.....	5.1	7.0

Source: Congressional Budget Office.

The bill makes use of a complicated formula to derive a number as the basic annual control limit. The rationale for the two major components of the formula has been questioned. It has been suggested that the GNP deflator fails to accurately measure changes in the price of goods and services paid for by hospitals. On the other hand,

it does measure the general rate of inflation in the economy, and proponents of its use argue that it is a reasonable base standard for hospitals. The second portion of the formula is an arbitrary and declining allowance for intensity or improvements in service. Additionally, the numbers used in calculating the revenue limit are based on prior time periods, and the limit is promulgated by the Secretary only once a year (with provision for adjusting the limit if the actual GNP deflator exceeds the GNP deflator used in the formula by more than 1 percent).

With respect to adjustments for increases or decreases in admission loads, the bill allows no increase for the first 2-percent increase in hospital admissions, over the base period. Over time, many hospitals will experience at least such an increase from the base period and will thus have to absorb costs related to such increases. However, the administration argues that without this "corridor" where admissions increase but allowed revenues do not, hospitals may admit additional patients whose cost per admission is low. Hospitals in certain regions with rapidly expanding populations will undoubtedly experience extensive growth in admissions over the base period. Such hospitals would have to absorb the initial 2-percent increase, and would be required to meet the criteria of the exception process for any increases in admissions which exceed 15 percent of their base year (1976) admissions.

It has been suggested that the revenue limitation included in the bill does not take into consideration past performance of individual hospitals. Hospitals that have performed more efficiently than other hospitals are subject to the same percentage ceiling on potential revenues, a ceiling that is applied to a base which is itself smaller than less efficient hospitals of the same type and size.

Alternate or additional proposals

Mr. Rogers offers a proposal which would make the following changes in the provision for adjusting the base year amount for the period between the hospital's accounting year ending in 1976, and the effective date of the program:

(a) allow each hospital to adjust the 1976 base for each of the intervening accounting years by the greater of (i) the increase in 1976 over 1975, or (ii) the average of the increase of 1975 over 1974, and 1976 over 1975, subject to the limitation described in (b),

(b) set artificial limits on the amount of increase allowed, in each of the intervening years at a minimum of 9 percent and a maximum of 20 percent.

Mr. Rogers offers a proposal which would make the following changes in the limit on increase in allowable revenue per admission:

(a) provide that the allowable increase (before adjustment) is $1\frac{1}{2}$ times the GNP deflator,

(b) compound the increase in each subsequent year so that in each year, the amount of increase allowed over the previous year's allowed revenues is $1\frac{1}{2}$ times the GNP deflator,

(c) require the Secretary to announce the annual limit allowed for hospital revenues quarterly. Each hospital would use the increase announced closest to the beginning of the hospital accounting year. Provide that if the figure announced by the Secretary in any succeed-

ing quarter of the hospital's accounting year exceeds the one in use by a percentage point, the higher limit would apply.

Mr. Carter's bill contains a provision directing the Secretary to develop an index reflecting hospital input prices within 2 years after the date of enactment. Such index would then be used to set the limit on allowable revenue per admission.

Mr. Carter's bill contains a provision designed to encourage the phase-out of duplicative services through insuring that volume increases associated with a shared-service agreement would be added to the base-year volume of the hospital providing the service. The hospital discontinuing the service would not be penalized by having its reduction in volume subtracted from its base-year volume.

Mr. Carter's bill contains a provision which would state that the admission load formula would not apply to hospitals in, or serving, medically underserved areas.

D. APPLICATION OF REVENUE LIMITS

Description of issue

A hospital's per admission revenue limit would be calculated separately by each of the cost-reimbursement programs from which it receives revenues. Blue Cross, medicare, medicaid and other cost-reimbursement payers would independently calculate the hospital's average revenues for the base year (including coinsurance and deductible amounts owed by the patient) that were attributable to the admission of the program's beneficiaries. The medicare intermediary for the hospital would provide the other cost-reimbursement payers the information about the hospital cost increases during the base year and the subsequent year, and about changed in its patient load since the base year, so that each cost payer could calculate the cost limit it is to apply to the hospital. Each cost payer would be responsible for assuring that its payments to the hospital (when added to patient copayment amounts) do not exceed this limit.

To establish a limit on hospital revenue from commercial insurance companies and individual charge payers, the hospital's medicare fiscal intermediary would calculate an average revenue per admission amount for the hospital's base year by dividing the hospital's total charges (whether or not billed or paid) by its total admissions for the year and adjusting the resultant figure in the same manner as the cost payers. The hospital would be responsible for keeping its billings to charge payers within the prescribed limit. The intermediary would monitor compliance with the revenue limits.

Discussion

The proposed method of applying the revenue limits is administratively simple. Health benefit programs that reimburse hospitals on the basis of cost would apply the revenue limits without having to establish additional reporting or audit procedures. Using information now routinely reported for medicare purposes, medicare intermediaries would monitor hospital charges to assure that amounts billed to charge payers are in accord with the limits. However, hospitals could be disadvantaged by the proposed approach. For example, if the proportion of a hospital's patients that pay charges decreases, the hospital

will lose revenues that it could not recoup since it could not raise its charges beyond the proposed limits. (Charge payers usually pay more than cost payers, and the excess is often needed to finance bad debts and various hospital activities.) Also, a hospital that seeks to comply with the revenue limits for its charge patients could inadvertently set its charges below the allowed level, thus losing revenue it could not recoup.

Alternate or additional proposals

Mr. Rogers offers a proposal which would allow the Secretary of HEW to adjust the revenue limit allowed per admission by payer, where the hospital requests an exception on either of the following bases:

(a) A cost payer such as a Blue Cross plan has expanded its coverage of services so that its reimbursement per admission in a particular hospital would increase by more than 3 percent (in the absence of the program's restraints); an increase would be allowed in base reimbursement per admission to recognize this increased coverage by the cost payer.

(b) A shift among payers results in loss of revenue equal to 3 percent of the hospital's base year revenue; an increase would be allowed in the limits applying to one or more payers to offset the effects of the shift among payers.

E. EXEMPTION OF NONSUPERVISORY PERSONNEL WAGE INCREASES FROM REVENUE LIMIT

Description of issue

The administration bill authorizes a modification of an individual hospital's revenue increase limit to allow for annual increases in the regular wages of nonsupervisory hospital employees. The Secretary of HEW would be required to adjust a hospital's revenue increase limit in any accounting year beginning before April 1979, if that hospital requests application of a modified limit and provides data necessary for its calculation.

The bill provides a formula to calculate the modified limit. A hospital's modified revenue increase limit would be calculated by adding together:

(A) the average percent increase in the regular wages of nonsupervisory employees during the accounting year for which the modification is requested, multiplied by the percent of those costs for inpatient hospital services attributable to such wages in the preceding accounting year; and

(B) the hospital's inpatient hospital revenue increase limit (or adjusted limit, if applicable) in the accounting year for which the modification is requested, multiplied by the percent of such costs attributable to all other expenses in the preceding accounting year. When calculating expenses attributable to regular wages of nonsupervisory employees or expenses attributable to other inpatient costs, only those costs that are allowable under medicare could be included.

Only increases in the regular wages of nonsupervisory employees could be exempted from revenue limits.

Staff discussion

A recent study prepared for the Council on Wages and Price Stability indicates that although hospital employee wages have increased more rapidly than other wages in the economy, such increases have not contributed substantially to significantly higher hospital costs. With this in mind, the administration proposes to exempt increases in the regular (or cash) wages of nonsupervisory employees from revenue limits prescribed by its hospital cost containment program. The consequence of this proposal would be to shield these increases from potentially adverse effects of the cost containment program. If the exemption were not allowed, it is suggested that low-wage hospital workers might bear the brunt of the cost containment program. Without the exemption, such wage increases could be constrained by prescribed revenue limits, restricted even beyond prescribed limits, or eliminated entirely.

The exemption would apply only to annual increases in the regular wages of nonsupervisory employees. Total increases in labor costs would not be exempted from revenue limits. Once a hospital opted to use the wage passthrough provision, in subsequent years they would be allowed only the real percentage increase in wages for that portion of hospital costs.

It should be noted that the exemption would not be applied to all hospitals, since only hospitals under the Federal program requesting the exemption would be covered. For example, hospitals located in States which are exempted from the cost containment program would not be given the opportunity to request the exemption.

The discretionary nature of the wage increase exemption makes it uncertain how widely or how effectively this provision would be applied.

Alternate or additional proposals

Mr. Carter's bill contains a provision which would end the exemption of nonsupervisory personnel wage increases from the revenue limit when the hospital input price index is used to set the revenue increase limit. (This provision is contingent on approval of Mr. Carter's amendment incorporating the hospital input price index.)

F. EXCEPTIONS TO THE REVENUE LIMIT

Description of issue

Under the administration bill, exceptions to the annual revenue limit would be granted for major changes in patient load or for major changes in facility, capacity, or services, but only where the hospital meets a specified financial condition test, and where such changes are consistent with State health planning policies.

The Secretary of HEW may grant an exception from the revenue limit for an individual hospital where the costs of inpatient hospital services in the accounting year exceed costs in the base accounting year as a result of:

- (1) a change in admissions beyond a 15-pound increase or decrease from admissions in the base accounting year. (This exception is needed only for hospitals which had 4,000 or more admissions in the base accounting year.) If this exception is granted to

a hospital, the hospital is allowed more revenue for admission increases, and a smaller decrease in revenue for admission decreases than hospitals without an exception; or

(2) major changes in capacity or types of inpatient hospital services, or renovation or replacement of physical plant which increase inpatient costs per admission in the present accounting year over the previous accounting year by more than the intensity factor percentage allowed as part of the basic limit formula. This intensity factor percentage is equal to one-third of the difference between the average annual rate of increase in hospital costs over the preceding 2 years and the average annual rate of increase in the GNP deflator in that same period.

If this exception is granted to a hospital, that hospital would be allowed to increase its total revenues for that accounting year and all subsequent accounting years by an amount the Secretary estimates, at the time he grants the exception, would raise the hospital's current ratio (as defined in the bill) of assets to liabilities to no more than two.

A hospital may receive either of the exceptions only if the following two conditions are satisfied:

(A) The current ratio (as defined in the bill) of assets to liabilities is less than two. The current ratio of assets to liabilities is defined as the sum of the cash, notes, and accounts receivable (less reserves for bad debts), marketable securities, and inventories held by a hospital, divided by the sum of all liabilities of that hospital falling due in the accounting year for which the exception is requested, and

(B) The changes in admissions, capacity, character of inpatient hospital services, or the renovation or replacement generating the excess costs are found to be necessary by the State health planning agency.

HEW would be required to act on requests for exceptions within 90 days, or the hospital and the third-party payers could presume approval. Any hospital granted an exception would be subject to an operational review by HEW. The findings from such review would be made public, and any recommendations for improvements which are made as a result of the review would be required to be implemented in order to continue the exception.

Discussion

HEW has expressed the view that stringent criteria for exceptions are necessary to maintain the effectiveness and administrative simplicity of the program. Others have suggested that the administration's exceptions procedure is far too stringent and fails to recognize the unusual circumstances that different hospitals sometimes face.

Since to receive an exception, a hospital must demonstrate a current ratio of assets to liabilities of 2 to 1, or less, the number of hospitals eligible for an exception would be quite limited. It has been argued that hospitals would be compelled to "spend down" their assets in order to qualify for an exception. It is possible, however, that a hospital would prefer to cut back its services rather than spend its reserves in order to be eligible for an exception. It should be noted that hospitals approaching insolvency, but without the required changes in

volume or scope of services or capacity, would have no basis for seeking an exception under the proposal.

Additionally, the administration bill would allow no increase in revenues because of increases in admissions over 15 percent (for hospitals with more than 4,000 admissions) unless the current ratio test is met, regardless of the reason for increasing admissions. For example, if one facility in an area closes, and another's admissions increase significantly as a result, no increase would be allowed until the current ratio of the remaining facility falls to 2 to 1.

Alternate or additional proposals

Mr. Rogers offers a proposal which would provide for the following exceptions to the revenue limit, without requiring a hospital to meet the current ratio test:

(a) where the hospital can demonstrate that the increase in admissions occurs because another nearby facility has closed, or

(b) the hospital is located in an area of rapid population growth where continued large increases in admissions would be expected to occur.

Mr. Rogers offers a proposal that would allow a hospital to seek an exception when it meets the current ratio test, even if it cannot meet the criteria for changes in admissions or capacity, if it is the sole community provider, and has been determined to be necessary by the Health Systems Agency.

Mr. Rogers offers a proposal which would ease the current ratio test from 2 to 1 to 2.5 to 1.

G. EXEMPTION FOR HOSPITALS IN CERTAIN STATES

Description of issue

The bill proposes to exempt from the revenue limitations of the program hospitals in States which have in place cost containment programs meeting the following conditions:

(A) The aggregate rate of increase in revenues for inpatient hospital services allowed in the State program could not exceed the rate of increase promulgated under the Federal program.

(B) A State hospital cost containment program applying to inpatient hospital services must have been in effect for at least 1 year prior to the request for the waiver and must cover at least 90 percent of the hospitals of the type which would be included in the Federal program.

(C) The State program must apply to all inpatient care revenues of such hospitals in the State. In addition, the State program must have applied, for the year prior to the request for a waiver to at least half of such revenues (except medicare revenues).

(D) The State must have an approved plan for recovering any excess of total revenues.

Discussion

Currently, 25 States have rate review programs of various kinds. Whether the proposal intends to accommodate those States whose plans initially fail to meet the various criteria for waivers but can be adjusted for compliance at some immediate point in the future is

unclear. In addition, the bill raises a question of whether States with cost containment programs in development will or can be accommodated in the future.

Alternate or additional proposals

Mr. Rogers offers a proposal which would remove the inequity inherent in the test applied to a waived State by providing that the aggregate rate of increase in inpatient hospital revenues for hospitals in such a State will be equal to the estimated actual aggregate increase allowable under the Federal program, rather than the limit initially promulgated by the Secretary.

Mr. Rogers offers a proposal which would allow recognition of alternate State programs regardless of the length of time they have been in operation.

Mr. Carter's bill contains an alternative approach. Under H.R. 8687, the states would have the primary responsibility for initiating cost containment programs with the Federal role limited to oversight and technical assistance when a State has established a hospital budget commission. (The Federal cost control plan would be essentially residual, operating only where no State commission was established.) The Federal government would pay for the start-up costs of state programs.

Federal oversight of state programs would be instituted through imposition of a Federal revenue limit (similar to H.R. 6575) and states would be required to contain the aggregate rate of increase in inpatient hospital revenues at or below the estimated aggregate increase allowed under the Federal program. States would also be required to institute formal, cooperative agreements between State health planning and development agencies, Professional Standards Review Organizations, and State budget commissions.

The Secretary would be empowered to rescind the state's exemption from the Federal revenue limitation program if the State was not able to conform with these requirements. The Secretary would also be directed to assist those states who were having difficulty complying with the Federal requirements.

In operating a State budget commission, the state would be required to establish a State Commission on Hospital Budgets to prospectively review and approve hospital budgets within the State and an advisory council representing providers, payors, consumers, planners, and PSROs. Other requirements would include uniform definition of costs, use of positive incentives, public disclosure of budgets and conflicts of interest, and the annual submission of budgets and associated volume levels. The choice of a specific budget review methodology would remain with the State.

H. IMPROPER CHANGES IN ADMISSIONS PRACTICES

Description of issue

A hospital subject to the revenue limit would not be permitted to change its admissions practices in order to reduce the proportion of its inpatients whose reimbursement to the hospital is expected to be less than the allowable inpatient charges.

If another hospital believes that this practice is occurring, it may submit a written complaint to the Health Systems Agency describing such practices by such hospital or hospitals. The agency would be required to investigate all such written complaints.

If the agency, after investigation, determines that the complaint is justified, the Secretary may exclude the hospital found committing such practices from participation in programs authorized under titles V, XVIII, or XIX of the Social Security Act.

Staff discussion

Under the administration's bill, a hospital's revenues would not be reduced even though the hospital reduces its admissions load down to a certain level. The "antidumping" provision of the bill is intended to assure that the hospital does not secure such benefits by improperly transferring or otherwise refusing to admit either patients who are unable to pay their way in whole or in part or patients whose conditions would require more prolonged, and thereby expensive, care than the typical admission. If such practices were to occur, certain institutions with already large proportions of these patients might experience even greater admissions of such individuals.

It has been suggested, however, that the proposal would not be effective since only another hospital could file a complaint, the Health Systems Agency might not be as effective in investigating such complaints as would program integrity units of the Department of Health, Education, and Welfare, and that the penalties (exclusion from the medicare or medicaid programs) for "dumping" are out of proportion with the seriousness of the offense.

Alternate or additional proposals

Mr. Rogers offers a proposal which would allow individuals as well as hospitals to initiate complaints, and which would designate the Secretary of HEW as the party responsible for investigating the complaint and determining the appropriate penalty.

Mr. Rogers offers a proposal which would provide for a penalty of \$2,000 for each patient denied admission, in place of loss of participation in medicare and medicaid.

I. ENFORCEMENT PROVISIONS

Description of issue

Compliance with the revenue limits would be enforced in a number of ways. The Federal medicare program and nongovernmental cost reimbursement programs would be required to disallow or recoup reimbursement amounts in excess of the revenue limits. Nongovernmental cost reimbursement programs would be subject to a Federal excise tax of 150 percent of payments in excess of the revenue limit.

State medicaid and title V programs would be penalized for payments in excess of the revenue limit by the loss of the Federal share for that portion of their program costs.

Hospitals that receive reimbursement in excess of the revenue limit, whether from a cost payer or a charge payer, would be subject to a proposed Federal excise tax of 150 percent of the overpayment. A hospital whose charges per stay exceed the allowable rate of increase during

the year may be exempted from the penalty if it establishes an escrow account into which excess revenues from charge payers are deposited. Such amounts would be deducted from the amounts to which the hospital would be entitled from charge payers in the subsequent year.

The proposal also authorizes the Secretary of HEW, at his discretion, to exclude any hospital or cost payer that is in violation of the revenue limits from participating in medicare, medicaid, or title V of the Social Security Act.

Discussion

In view of the magnitude of the proposed penalties for paying or receiving reimbursement in excess of the proposed revenue limits, it is unlikely that they would ever need to be invoked. Cost payers and hospitals could avoid the penalties by having the hospital return overpayments.

Similarly, a hospital that has collected too much from its charge payers could avoid the sanctions by placing the excess charges in escrow and using them to supplement income from reduced charges in the following year. This mechanism has been included because it would not be feasible for the hospital to refund overpayments to the various charge payers. The result of this escrow-account approach is that patients receiving services in hospitals in violation of the limit would be partially subsidizing the care of patients receiving services in that hospital in a subsequent year.

Alternate or additional proposals

Mr. Rogers offers a proposal that would provide that no hospital would be subject to the penalty imposed in the law at the end of the first year of the program, if by the end of the second year the total increase in revenue per admission over the 2-year period was within the allowed increase for the 2 years.

Mr. Rogers offers a proposal which would allow a hospital to be released from requirements to hold excess charge revenues in escrow to the extent they can demonstrate that actual collections have not exceeded collections by more than the allowed amount in the previous year.

J. DISCLOSURE OF INFORMATION AND REVIEW OF DETERMINATIONS

Description of issue

(1) Disclosure of fiscal information. Each hospital would be required to submit to its local health systems agency the following: (1) by March 1 and September 1 of each year, its average semiprivate room rate and the charges for 10 other services which the health systems agency finds are most frequently used or are most important for comparing hospitals; (2) by March 1 and September 1 of each year, all cost reports submitted to cost payers; and (3) annually, the hospital's overall plan and budget as described under medicare legislation (section 1861(z) of the Social Security Act), if the hospital participates in medicare. The health systems agency would be required to publish every April 1 and October 1 the information it receives, in a manner so that comparisons can be made among hospitals in its health service area. If a hospital fails to submit any of the information de-

scribed above, it could be excluded, at the discretion of the Secretary, from titles V, XVIII, or XIX.

(2) Review of determinations. Except for determinations concerning exceptions and changes in admission practices, any determinations made in applying the provisions of the cost containment program to an individual hospital would be subject to review and hearing procedures by the Provider Reimbursement Review Board similar to review procedures under the medicare program.

Staff discussion

It has been suggested that lack of public knowledge about comparative charges by hospitals contributes to the lack of cost consciousness in the field. It has also been suggested that the provisions for disclosure of fiscal information be extended to include such information as full financial statements including receipts and expenses, and total assets and liabilities; governing board members and top administrative and medical staff; salaries and fringe benefits of top administrators and medical staff; and other information similar to that required by IRS for nonprofit hospitals.

Alternate and additional proposals

Mr. Rogers offers a proposal which would broaden the information to be disclosed to include all room rates, charges for 30 services specified by the Secretary, and an annual report containing ownership and management information, available to the public.

Mr. Rogers offers a proposal which would allow the Secretary to reduce medicare, medicaid, and title V funding by up to 5 percent if the hospital fails to provide the required information, rather than denying participation from those programs as the only available sanction.

K. ADDITIONAL ISSUES

Description of issue No. 1

The administration bill sets a limit for increased revenues for all hospitals. If a hospital exceeds that limit, it is penalized. But if a hospital succeeds in holding costs below the limit, there is no reward for efficiency. Cost payers would reduce their payments accordingly.

Additional proposal

Mr. Rogers offers a proposal which would provide that any hospital which held costs per admission to an amount less than that allowed under the program would be able to keep up to one-half of the difference for each admission paid for on a costs basis, to the extent that they will spend the incentive (i) to pay an outpatient deficit, (ii) to retire long-term debt, or (iii) for any other reason which the Secretary finds will not contribute to operating costs and is in the public interest.

Description of issue No. 2

The administration bill does not attempt to compare the cost performance of similar hospitals. A cost containment program cannot be based on the comparative performance of hospitals in containing costs unless comparable data on costs are available. Acquisition of com-

parable data requires a sophisticated uniform reporting system, and may require uniform accounting.

Additional proposal

Mr. Rogers offers a proposal which would require the Secretary to implement uniform reporting systems and to develop uniform accounting systems for institutional providers. The Secretary would be authorized to require use of such part of the accounting system as he finds necessary after a 2-year period of evaluation of the use of uniform reporting.

Description of issue No. 3

Currently, some practitioners, particularly radiologists, pathologists, and anesthesiologists, are paid for their services in hospitals on a percentage basis, related to charges for all services delivered in the departments of the practitioners' specialty.

A major defect of the so-called percentage arrangement is that the physician's compensation is based in part on charges for services performed by hospital technicians—services in which the physician may have had little or no personal involvement. Thus, the physician can benefit greatly with little or no additional effort on his part if, as has been the trend, the volume of services performed by the hospital employees in his department increases. Such increases have occurred as the result of improved automation and other technological changes, as well as by medical advances that have required increased use of hospital's ancillary services. The physician can also benefit automatically if the hospital increases its charges for services performed by the department. Percentage arrangements have also been criticized on the ground that they provide a financial incentive for the physician to induce increased utilization of his department's services.

Additional proposal

Mr. Rogers offers a proposal which would deny medicare or medicaid reimbursement for any portion of cost payments or charges which result from payment arrangements to hospital-based physicians which are based on a percentage of the costs of services delivered in that specialty in the hospital.

Description of issue No. 4

Current medicare and medicaid law and regulation require that a hospital providing skilled nursing facility services must have a distinct part of the hospital identifiable as an extended care facility. Small rural hospitals often have low occupancy rates and beds available to provide long-term care services, but are unable to use these beds for that purpose because reimbursement is not available unless they are located in a distinct part. Rural hospitals have been unable to operate more cost efficiently by using these beds as "swing" beds to provide hospital services at one point and long-term care services at another.

Additional proposal

Mr. Rogers offers a proposal which would allow rural hospitals to be reimbursed for long-term care services on a simplified cost basis without requirement of a distinct part or a separate cost finding.

Description of issue No. 5

The physician is generally the key to the determination of use of medical care services, both in and out of the hospital. While physicians receive extensive training, their course of study usually does not include information concerning the growing costs of health care, the lack of constraints in the system to hold down health care costs, and the responsibility of health care providers to be concerned with costs—both for the individual and the health care system as a whole.

Additional proposal

Mr. Rogers offers a proposal to provide special project grants to Schools of Medicine to train students to understand the cost implications of their activities for the medical care system, and to exercise cost consciousness.

ISSUES RELATED TO TITLE II—LIMITATION ON CAPITAL EXPENDITURES

Description of issues

The administration bill would require the Secretary of HEW to set an annual limit on hospital capital expenditures. The national limit could not exceed \$2.5 billion. Expenditures by Federal hospitals and hospitals primarily serving HMO's would not be included in the limit. The limit would be apportioned among the States on the basis of population for the first 2 years of operation. Subsequently, the funds could be apportioned on the basis of a variety of factors, including population, construction costs, population patterns, need for facilities and equipment, need for modernization, and other factors found to be important.

In addition to the expenditure limits, the Secretary would be required to set national standards for hospital bed supply in relation to population and for hospital occupancy rates. The bed supply standard could not exceed 4 beds per 1,000 population, and the occupancy standard could not be lower than 80 percent (although different standards could be set for areas with special needs). These standards would be applied to each health service area (not to individual hospitals) for purposes of approving capital expenditures under State certificate-of-need programs.

Under existing law, State certificate-of-need programs review and determine the need for new institutional health services, health care facilities, and health maintenance organizations. Only those services, facilities, and organizations granted a certificate-of-need are to be offered or developed within the State. The program is administered by the State Health Planning and Development Agency (the so-called State agency) which considers the recommendations of the health systems agencies within the State.

The administration proposal would expand upon existing law to require that a certificate-of-need specify the maximum expenditure allowable for the approved activity. Furthermore, in the case of capital expenditures for hospitals, a State could not issue certificates which in the aggregate, exceed the State's capital expenditure limit. However, a State would be allowed to carry over into the succeeding year amounts authorized but unexpended in the current year. In situations

involving partial or total closure of a hospital found by the State agency to be providing inappropriate institutional health services, certain undepreciated costs for that facility could be added to the total amount a State could allocate in a given year for hospital capital expenditures.

The administration bill would also prohibit States from issuing certificates-of-need for new institutional health services or health care facilities if there would be a resulting increase in hospital beds in a health service area whose bed capacity exceeded or occupancy rate fell below the established standards.

An exception to the bed moratorium would be allowed if a State permanently closed twice as many beds as were being added. Any unused allowance for new beds resulting from such a closure could be carried over into the succeeding year. For example, if a State with excess capacity or substandard occupancy closed 200 beds in a given year, it would be allowed to add 100 new beds. However, if the State added only 50 new beds in that year, it could carry over into the succeeding year an allowance for 50 additional new beds.

The definition of "capital expenditure" is similar to that used under section 1122 of the Social Security Act (that is, expenditures which exceed \$100,000; change the bed capacity of a facility; or substantially change the services of a facility), but has been modified to include facilities or equipment obtained under a lease or acquired through donation. The cost of certain predevelopment activities would also be included.

The proposal would extend from 90 days to 1 year the period of time currently allowed for review of certificate-of-need applications and other reviews required for purposes of title XV. This would allow health systems agencies and States to carry out one or two review cycles each year in which projects would go through a two-step process. First, a determination of need would be made; then projects would be ranked in priority order and the capital limit would be applied.

In States without a certificate-of-need program, medicare and medicaid reimbursement to hospitals undertaking capital expenditures which were not approved by the Secretary would be reduced by 10 times the amount of depreciation, interests, and return on equity capital associated with unapproved expenditures.

The Federal tax exemption on State obligations would be withdrawn for any bond issued to finance unapproved capital expenditures or expenditures which result in bed supply in excess of prescribed standards.

Discussion

Rising capital expenditures are an important—some believe the most important—source of hospital cost increases. These expenditures comprise about 13 percent of all spending by non-Federal short-term hospitals. If there is no change in current policy, they are expected to reach \$8 billion in 1978 and \$14.1 billion by 1982. The annual increases in capital expenditures have been slightly higher than those of total hospital spending, averaging 15.5 percent between 1970 and 1975. Approximately half of this increase, or 8.2 percent, is attribut-

able to rising prices; the remainder reflects real growth in capital spending.

The administration has stated that constraints on capital expenditures are an essential component of cost control, and that steps must be taken to restrain the growth in bed capacity and duplication of technology. The proposed capital expenditure limits would reduce aggregate capital spending by more than 50 percent in the first year. The impact would be even greater in succeeding years since no provision is made to adjust the maximum ceiling of \$2.5 billion in later years. Some have argued that this limit would not even be sufficient to replace depreciating plant and equipment. Others, however, have proposed a complete moratorium on spending for 1 or 2 years.

Some fear that the capital limit might have an adverse effect on continued progress in medical research and technology. In addition, some have urged exemption from the capital limits for certain types of expenditures, for example, those necessary for energy conservation, replacement of equipment, plant maintenance, compliance with Federal, State, or local law or with industry or accreditation standards.

The distribution of the limit among the States has also been the subject of some discussion. Distribution on the basis of population alone does not take into account the relative need for services or for replacement of aging physical plant in different areas; for example, a State with a small population may have a greater need for new services than a larger State. The provisions for taking additional factors into account in allocating funds in subsequent years may alleviate this problem. The State distribution also does not take into account those specialty institutions which serve regional or even national populations, such as the Mayo Clinic or the Sloan-Kettering Institute in New York.

The national standards of a maximum of 4 beds per 1,000 population and a minimum occupancy rate of 80 percent would preclude the addition of new beds in most health service areas of the country. The national averages in 1975 were 4.5 beds per 1,000 population and an occupancy rate of 75 percent. Sixty of the 205 health service areas meet the bed ratio standard, and 31 meet the minimum occupancy standard. Only 17, or 8 percent of the health service areas, meet both standards.

Some have recommended that the requirements be extended beyond short-term general hospitals to cover other types of facilities as well, such as skilled nursing homes, long-term care facilities, et cetera. Others are concerned over the exclusion provided for VA hospitals and other Federal health facilities. Some feel that the certificate-of-need provisions should be further strengthened to include all major capital expenditures, regardless of location. In this connection, it is feared that by restricting capital investment by hospitals, the bill might indirectly encourage purchase of major equipment by physicians and other exempt providers.

State and local health planners have expressed concern over the need for more adequate staffing and funding to administer the expanded certificate-of-need provisions. Others have pointed to the

potential for political corruption as institutions compete for limited capital allocations.

The administration bill addresses the problem of existing excess capacity indirectly. Estimates of current overcapacity run as high as 10 percent of all hospital beds. However, section 114(c) of the administration bill allows a hospital's revenue base to remain unchanged if it terminates a service found to be inappropriate by the health planning agency. Thus, a hospital which closes a service would have increased eligibility under the revenue limitation. The other provision in the bill for encouraging reduction of existing excess capacity would be the prohibition against new bed construction in the absence of existing bed closure. Some have argued that this might work toward maintenance of the status quo, especially among hospitals concerned about revenue loss resulting from closing beds. Responsibility for approving the closure of beds would presumably rest with the State agency, which might be reluctant to force bed closure in one hospital in order to allow for expansion at a neighboring facility.

A variety of suggestions have been made for possible changes in the bill to address some of the problems identified. For example, those who believe that the proposed limit of \$2.5 billion is arbitrary have argued for a ceiling related to some measure of need. One proposed method would be to impose a ceiling of \$2.5 billion in 1978 but to let the limit grow over time. It is suggested that such an approach would permit expenditures to rise over time as replacement and modernization of plant and equipment becomes necessary.

Alternatively, suggestions have been made to establish an exception process for proposals in excess of the ceiling. (Some have suggested that this approach might be used in conjunction with a moratorium of limited duration on all capital expenditures.) States, for example, might be granted authority to raise their limits to the extent that they could demonstrate a pressing unmet need to modernize existing capacity. Other justifications for exceptions might include proposed use of Federal energy funds to improve insulation, or other improvements that would clearly save money in future years.

In order to deal with the problem of expenditures outside the institutional setting, suggestions have been made to extend certificate of need coverage to large purchases of equipment not under hospitals' control, such as those in physicians' offices, group practices, and laboratories.

Suggestions have been made to strengthen the current section 1122 program to require State planning agency approval of capital expenditures before any Federal reimbursement under Social Security Act programs is permitted. Under present law, medicare and medicaid only withhold reimbursement of depreciation, interest, and return on equity if a State disapproves an expenditure. Some have also pointed to the need to bring uniformity to the requirements of the certificate of need and section 1122 programs so that States can operate both more easily.

Additional proposals

Based upon the issues described above and the testimony presented on both H.R. 6575 and H.R. 8121 a number of changes to title II are proposed for the subcommittee's consideration.

A. Proposals related to the capital expenditure limit

1. *Inflation adjustment.*—*Mr. Rogers* offers a proposal to require the Secretary to increase the limit annually to reflect increases in the cost of construction. Under the administration bill the real dollar value available to make the capital expenditures will decline over time as a result of inflation. This change would allow hospitals purchasing power for capital goods to remain constant over time.

2. *Distribution of the limit.*—*Mr. Carter's* bill changes the method of distributing the limit among the States from population alone to the ratio of historical cost (minus accumulated depreciation) of health care institutions within the State to the population of the State. Use of the ratio would mean that States with relatively less investment in health care institutions would be allowed to spend more capital, thus helping to alleviate the maldistribution of health care resources.

3. *National health resources.*—*Mr. Rogers* offers a proposal which would give special consideration to institutions which serve patients from across the country. This proposal would require the Secretary to retain 10 percent of the capital expenditure limit to cover capital expenditures for such institutions. Any project proposed by such an institution and approved at the State level would be forwarded to the Secretary. If the Secretary approves the application he would then charge against the retained sum the portion of total project cost which is related to the percentage of patients served by the hospital who came from outside the State. This would mean that the State in which the institution is located would bear only its share of the cost of the capital expenditure. The portion of the capital expenditure reflecting out-of-state patient use of the institution would be charged against the retained sum by the Secretary. The amount of the retained sum not used in a fiscal year would be allocated to the State for use in the following year.

Mr. Carter's bill contains a similar provision which would give special consideration to institutions which draw patients from across the country and allow the Secretary some discretion in providing for significant unmet health needs in areas where the formula distribution was insufficient. This proposal would require the Secretary to retain 20 percent of the capital expenditure limit for these two purposes. The application of the limit to national resource centers would be the same as the proposal above.

4. *Report by the Secretary.*—Arguments have been raised on both sides as to the adequacy of the \$2.5 billion. *Mr. Rogers* offers a proposal that would require that the Secretary examine the adequacy of the capital limit and report to the Congress within 2 years any need for change. This might be accomplished by examining the projects which have been found to be needed but were not of sufficient priority that they were approved under the capital expenditure limit. It would also require an examination of the projects which were approved in order to make a judgment if the capital expenditure limit as now established is too high.

B. Modifications of the certificate of need and section 1122 programs

1. *Consistency between the two review programs.*—As currently operated, the certificate of need program required under title XV and the section 1122 program authorized under the Social Security Act are

inconsistent in a number of ways. This makes operating both programs difficult within a State and is particularly confusing to the providers who are subject to review. *Mr. Rogers* offers a proposal for changes in the section 1122 program to eliminate those inconsistencies. The proposal includes making the minimum requirements concerning the procedures and criteria by which a State health planning and development agency or health systems agency undertake review activities consistent with title XV requirements.

The proposal places the section 1122 program on the same basis as certificate of need by requiring that the State approve capital expenditures before Federal reimbursement under titles V, XVIII, and XIX of the Social Security Act would be permitted. The existing 1122 program merely withholds reimbursement of depreciation, interests, and return on equity if a State disapproves a capital expenditure.

In addition, the existing 1122 program requires the Secretary to determine if reimbursement should be withheld once a planning agency disapproves a capital expenditure. *Mr. Rogers* offers a proposal that this provision be eliminated and in its place allow a State planning program with its appeals process to render decisions concerning a project's need which the Federal Government would simply accept for reimbursement purposes.

Under the current 1122 program a provider once having obtained approval has 1 year in which to incur the obligation for the proposed capital expenditure or the approval under the program is terminated. This provision is designed to prevent a person from not proceeding to develop a service or facility or make a capital expenditure and therefore meet a community need once approval (a franchise) has been obtained. *Mr. Rogers* offers a proposal to add a similar provision to title XV that would require the health planning agency to annually review the progress of a project's development once a certificate-of-need has been issued. If adequate progress is not being made the certificate-of-need would be withdrawn so that the agency can consider other ways of meeting the need.

Mr. Rogers offers a proposal to establish a capital expenditure threshold for both programs at \$150,000 in order to recognize the inflation which has occurred since 1972 when the \$100,000 capital expenditure threshold was established in section 1122.

2. *Expansion of program coverage.*—The capital expenditure limit of title II applies only to short-term hospitals. By placing controls on investment in hospitals incentives are created for the purchase of major medical equipment outside the institutional setting. This is particularly likely to occur when a specific proposal for equipment has failed to get approval under the capital limit program. The existence of such a loophole is likely to lead to proliferation of expensive medical equipment in physician's offices and health centers throughout the Nation. To avoid this *Mr. Rogers* offers a proposal that expensive medical equipment regardless of the setting in which it is operated be added to the required coverage under certificate-of-need and section 1122. More specifically, any capital expenditure for major medical equipment which costs in excess of \$150,000 or is identified by the Secretary as having major impact on health care costs would be covered. This latter category of equipment is included so that certain

types of equipment under the \$150,000 threshold could be added to the program coverage if the Secretary determined that such equipment is likely to be used in an inappropriate or inefficient manner.

Mr. Rogers offers a proposal to add home health services to the required coverage under both programs. Until recently these services were covered under the section 1122 program. When the Congress enacted title XV it was expected that the 1122 coverage would remain the same and in addition would apply to minimum required coverage under certificate-of-need. However, HEW deleted the coverage of home health services from both programs. Since this was not consistent with congressional intent a proposal to add home health services is made for the subcommittee's consideration.

3. *Sanctions*.—As the 1122 program is currently structured, if a capital expenditure is made even though it has been disapproved by the State health planning agency, depreciation, interest, and return on equity associated with that capital expenditure will be withheld under titles V, XVIII, or XIX. The administration's bill increases that withholding to 10 times depreciation. The assumption is that this larger sanction will be more effective in discouraging providers from proceeding with capital expenditures that are disapproved. The intent of the administration's proposal seems to be that we should not participate in paying for any of the costs associated with the capital expenditure that is disapproved. Since it is not clear whether denial of an amount equal to 10 times depreciation fairly or unfairly accomplishes this end, *Mr. Rogers* proposes that the sanction be changed to simply withholding both depreciation and operating costs associated with a capital expenditure which has not been approved by the health planning agency.

4. *Institutional planning*.—Title I requires that the budgets and 3-year capital expenditure plans which hospitals have been required to annually develop (under section 1861(z) of the Social Security Act) be provided to the health systems agency. This should allow the HSA to better accomplish areawide planning by knowing about the plans which institutions have developed. So that institutions take seriously this institutional planning requirement and that the development of plans is more than just a paper exercise, *Mr. Rogers* proposes to prohibit an HSA or State health planning and development agency from approving a capital expenditure which an institution had not included in its 3-year capital expenditure plan. Exceptions could be made for emergencies.

C. Enforcement of planning decisions

Sellers of major medical equipment.—Many have pointed out that it will be difficult to enforce the requirement that all capital expenditures for major medical equipment be approved by the health planning process given existing certificate of need and section 1122 sanctions. To help assure that all such expenditures for major medical equipment are approved by the health planning process in each State *Mr. Rogers* proposes to require that all those involved in selling major medical equipment must assure that the purchaser has obtained certificates-of-need or section 1122 approval prior to its sale. Failure to comply with this requirement would make the seller liable for a civil penalty in an amount not to exceed five times the sale price of the equipment.

D. Implementation

Implementation process and timetable.—It is important that there be timely and fair implementation of the capital controls proposed in title II throughout the Nation. *Mr. Rogers* offers a proposal that following the enactment of this legislation no new services, facilities, or capital expenditures which are defined as being subject to review by this legislation and conform to its other provisions would be reimbursed under Federal programs if they are offered, developed, or acquired without certificate-of-need or 1122 approval. Exceptions would be made when approval was required because of an emergency. The Secretary of HEW would have 120 days to revise the regulations that define an acceptable certificate-of-need or section 1122 program. The prohibition against reimbursing the new services, facilities, or major medical equipment could then be lifted on a selected basis in each State as a State revised its certificate-of-need program to be in conformance with the law and regulations or revised the 1122 agreement with the Secretary of HEW and was able to undertake the conduct of reviews. This might mean, for example, that a State could carry out reviews of hospital proposals under the capital expenditure limit even though it had not yet modified its certificate-of-need program to cover purchases of major medical equipment by private physicians. However, these purchases would be prohibited until a State was able to approve or disapprove them.

The administration bill proposes to have the Secretary review and approve capital expenditures where a State does not have an acceptable certificate-of-need program or participate in the section 1122 program. Several have questioned the wisdom of giving the Department of HEW this type of role. Given the implementation process outlined above, secretarial review of proposed expenditures is unnecessary and *Mr. Rogers* offers a proposal that this provision be deleted.

Under title XV, each State has 2 years of conditional designation to develop an adequate health planning program and be fully designated. The additional requirements imposed by this title will make it difficult for States to be ready for this in 2 years. *Mr. Rogers* offers a proposal to permit a State up to 3 years of conditional designation.

ADDITIONAL ISSUES RELATING TO THE DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICE

Description of issue

The number of hospitals in the United States relative to population has been declining in the past 20 years. There were 32 hospitals per million population in 1955; that number has declined to 28 per million in 1975. There also has been a tendency for hospitals to expand, so the number of beds per 1,000 population has increased from 3.48 in 1955 to 4.48 in 1975.

Not only have hospitals grown in size, but they have acquired much new technology and expanded the scope of their services. This has caused a dramatic increase in the number of personnel per 100 hospitalized patients. There were approximately 2 employees per hospitalized patient in 1955, nearly 2.5 in 1965, and in 1975 that number rose to 3.4.

Studies have estimated that there is a national excess of at least 100,000 acute hospital beds. The Congressional Budget Office estimates that to reduce the bed to population ratio to 4 per 1,000 by 1982 would require closing approximately 130,000 beds.

Studies have also shown that there is an excess of "high intensity" service facilities and other identifiable service units in some areas of the country. These services are often underutilized due to duplication of the service in nearby institutions. Although the utilization standards by which these services are judged to be in excess are not easily established or as well recognized as are bed to population ratios and occupancy rates, testimony at the May 1977 hearings on H.R. 6575 confirmed that there is an excess of some hospital services.

If utilization is low because capacity is greater than the demand for care, hospitals will operate inefficiently. This inefficiency is particularly pronounced in the hospital industry because fixed costs represent approximately 50 to 60 percent of total costs.

The American Hospital Association estimates that the cost to maintain an unused bed is about 50 percent of the cost of an occupied bed. The annual cost of each unnecessary bed is approximately \$27,000, so the national cost of excess beds is approximately \$2.7 billion annually.

The additional cost which results from services being underutilized is very difficult to ascertain on a national basis, although it is clear that there are unnecessary costs incurred. When a hospital operates a coronary intensive care unit with a 50-percent utilization rate, for instance, the reasonable cost reimbursement is disproportionately high for each unit of service. Many have estimated that substantial savings would occur if this excess capacity were eliminated.

Discussion

The Administration's bill addresses the problem of excess hospital services indirectly. Under that bill a hospital which discontinues an inpatient service without a finding by the State planning agency that the service is unneeded will have its allowable revenue reduced by the amount of charges which were generated by that inpatient service. If the hospital requests and receives from the State planning agency a finding that the inpatient service to be discontinued is unneeded then the hospital's allowable revenue is not reduced.

The hospital which discontinues a service with such a finding by the State planning agency will reduce total costs and admissions by eliminating that service, but its allowable revenue will not be reduced. As a result, the hospital's future allowable increases in revenue per admission will be greater than the increases which would have been allowed if no service had been discontinued. If revenue per admission is higher, cost per admission may also increase.

There are several shortcomings in this provision. First, it may be difficult for the State planning agency or the medicare intermediary to know whether a hospital has discontinued an inpatient service. Thus, a hospital which discontinues a needed, but costly, service can realize the same revenue benefits unjustly. Second, a hospital which discontinues its excess services will not be limited to the same increase in revenues per admission as a hospital which has no excess services. And third, while this provision does encourage the discontinuation of inpatient service units and departments it is not a reward for dis-

continuing an entire hospital, and it is the closure of an entire hospital which saves the most money. One study prepared for HEW estimates that a 10-percent reduction in hospital capacity, accomplished by retiring entire hospitals, would reduce annual hospital expenditures by 8 times as much as a 10-percent reduction accomplished by across-the-board cuts at each hospital.

Several hospital representatives and the American Hospital Association have stated their support for this provision of the Administration's bill. They and HEW believe that it will result in the greatest reduction of excess services and beds.

Additional proposal

Mr. Rogers offers a proposal which would enact a program to assist and encourage hospitals to eliminate excess beds and services.

The purpose of the proposed program is to assist and encourage hospitals to voluntarily eliminate beds and services which are currently in excess of their need. Title II of the Administration's bill requires the promulgation of guidelines on bed ratio and occupancy rate. This proposal requires additional guidelines on appropriate supply and use of hospital services. (See section 2.) Because all future hospital capital expenditures would have to comply with those guidelines, this program is temporary in nature and presumes that once excess beds and services are eliminated a similar excess will not recur in the future.

1. Nature and duration of program

Within 6 months of the date of enactment the Secretary of HEW will establish a program which will provide financial assistance and encouragement for the discontinuance of unneeded hospital services. The program will last for 48 months. Any hospital which has been in operation for at least 2 years and which chooses to participate by discontinuing unneeded services may apply to the Secretary for a debt payment, incentive payment, or conversion payment. The Secretary will approve or disapprove the application.

2. Guidelines for hospital services

Discussion

Section 1501 of the Public Health Service Act, enacted January 4, 1975, required the Secretary to promulgate "standards respecting the appropriate supply, distribution, and organization of health resources." Those standards have not been issued.

Recent evaluations of the effectiveness of the planning law, the National Health Planning and Resources Development Act of 1974 (titles XV and XVI of the Public Health Service Act), have been critical of the performance of health systems agencies, the State planning agencies, and the State certificate-of-need programs. These reports state that these agencies, with some exceptions, have not significantly reduced the amount of capital expenditures made by hospitals for new facilities and services. Two reasons cited for this failure are the lack of resource constraints and of accepted guidelines for the appropriate supply and utilization of hospital services. It is argued that these agencies will not be effective until their planning review includes widely accepted guidelines of supply and use and limits on

the dollar value of capital expenditures. Arguments against such guidelines and resource limits are based on concern that the Secretary of HEW should not be promulgating national guidelines, however sensitive to local needs they are designed to be, and that resource limits will arbitrarily prevent needed expansion and renovation of hospital services.

This program will require such guidelines and title II of the Administration's bill would set a national and state resource (capital expenditure) limit.

Proposal

Within one year of the date of enactment the Secretary of HEW will promulgate guidelines respecting the maximum appropriate supply of hospital services within health service areas measured by the number and type of hospital beds and the supply and type of major medical equipment and services in hospitals and the minimum appropriate rate of utilization of such hospital services within health service areas. The guidelines will be used by the health systems agencies (HSA's) and the State planning agencies in identifying excess hospital beds and services for purposes of this program and in making future planning decisions on the development of new services. The guidelines may vary with respect to a particular health service area to take into account special characteristics of that area.

3. Planning agency role

Upon establishment of this program the HSA's and State planning agencies will describe in their respective health plans the actions required by hospitals to reduce excess capacity. These plans must comply with the guidelines promulgated by the Secretary and they may comply with any additional guidelines issued by the State planning agency.

The State planning agency will recommend a hospital's application to the Secretary to discontinue unneeded services after the HSA reviews and recommends it to the State planning agency. The Secretary may not approve an application which a State planning agency recommends not be approved. The State planning agency, after considering the HSA's recommendations, must approve any service which will be developed with incentive or conversion payments under this program (even if review is not presently required).

No later than six months before expiration of the program the State planning agency, after considering the HSA's recommendations, will designate the hospitals which must discontinue services in order to bring the health service area in compliance with the guidelines promulgated by the Secretary.

Additional funding

The HSA, as a local agency, and the State planning agency, are in the best position to designate the hospital services which are in excess. This program, however, requires the planning agencies to undertake several new functions. Those agencies have stated that they will need additional funding support to acquire adequate staff to perform these new duties.

4. Priority for approval by Secretary of hospital applications

The Secretary will consider the recommendation of the State planning agency and will give priority to applications which assist health service areas in meeting the guidelines promulgated by the Secretary or which result in the greatest reduction in hospital revenues within a health service area. The Secretary may not approve an application which a State planning agency recommends not be approved.

5. Discontinuance of entire hospital

Hospitals which discontinue providing all inpatient health services may apply for a debt payment and an incentive payment. The debt payment will be the lesser of the total outstanding financial obligation attributable to the equipment and facilities or the amount of unexpended depreciation attributable to the equipment and facilities, less the fair market value of the equipment and facilities. The debt payment will also include any other debt expenses (such as call premiums) which result from the financial obligation being satisfied before due.

The incentive payment will be the lesser of 5 percent of the revenues reported by the hospital during its last medicare reporting period, but no more than \$500,000, and the amount the applicant hospital will expend for any of three authorized purposes. The hospital may spend that incentive payment by (1) planning, developing, and delivering ambulatory care services, home health care services, or long-term care services for the community which the hospital served, (2) if the applicant hospital merged with another hospital, preparation of that hospital to serve patients of the closed facility, or (3) providing reasonable termination pay for personnel who will lose employment because of the applicant hospital's closing.

If the incentive payment will be used to plan, develop, or deliver other services, those services must be determined to be needed by the State planning agency, after consideration of the recommendations of the HSA with jurisdiction over that community, even if the services to be developed are not presently covered by the State certificate-of-need program. If approval is not received, the Secretary may not grant that portion of the incentive payment. If the applicant is approved to develop ambulatory care services in the community, it will be given a priority for grants under section 330 of the Public Health Service Act, for National Health Service Corps personnel, or for other Federal assistance for the development of those services.

6. Discontinuance of identifiable service units

A hospital which discontinues an identifiable service unit, as defined by the Secretary, may apply for an incentive payment equal to 30 percent of the charges reported by the hospital for such unit during the last medicare reporting period. The incentive payment may be no more than \$200,000. The hospital may also include in its costs, for reimbursement under title XVIII and XIX, losses incurred in connection with the sale or disposition of the equipment or facilities used in providing the discontinued service unit.

Medicare and medicaid comprise approximately 40 percent of hospital charges, so 40 percent of the loss from sale of the equipment or

facilities will be covered. The incentive payment can be used to cover other costs associated with discontinuing the service, such as the retraining of the unit's employees.

7. Conversion of identifiable part of facility

A hospital which converts underutilized beds or facilities in an identifiable part of its hospital into a long-term care facility or ambulatory care facility may apply for a conversion payment of 50 percent of the reasonable cost of such conversion. The Secretary will define "reasonable cost." The Secretary may not approve a conversion payment if the State planning agency, after consideration of the recommendation of the health systems agency, determines that the long term care or ambulatory care facilities and services are not needed.

8. Revenue base of applicant hospital and other affected hospitals

The revenue base of the applicant hospital will be reduced by the amount of revenue which was generated by the discontinued service.

If a hospital in the same area has an increase in admissions or must expand its facility to provide services to the additional admissions, it will be allowed additional revenue under the exceptions process so that its financial position will not be impaired.

9. Incentive payments to HSA's

If a hospital receives an incentive payment for discontinuing its entire operation or an identifiable service unit, the HSA for the area in which the hospital is located will receive an incentive payment equal to 10 percent of the applicant hospital's incentive payment. The payment may be used by the HSA to develop needed services in the community which lost the hospital services.

10. Funding

All payments under the program will be made in one payment from general revenues.

11. Penalty for noncompliance

As explained in section 3, six months prior to expiration of this program the State planning agency will designate the hospitals which have excess capacity which must be discontinued in order to bring each health service area in compliance with the guidelines promulgated by the Secretary. Any hospital so designated when the program expires which has not discontinued the excess services will have its reimbursement under title V, XVIII, and XIX reduced by 5 percent. The penalty will remain in effect until the service is discontinued.

The hospital so designated may apply to the Secretary for an extension of the time required to discontinue the service. The Secretary, after considering any recommendations of the State planning agency and the HSA, may grant an extension for good reason. The Secretary will specify the time within which the hospital will discontinue the required service, but in no case will the extension exceed in the aggregate two years.

12. Study of program

The Secretary will make a study of the first 25 applications approved under this program to determine the effect on the elimination of unneeded hospital services. The Secretary will report the results of the study to Congress with his recommendations for any revisions

in the program. The Secretary will not delay the program while the study is proceeding.

Additional proposal

Mr. Carter's bill contains a proposal which is designed to eliminate excess hospital beds and services. This proposal would grant the State Health Planning and Development Agency (SHPDA) the authority to designate unneeded services and facilities as surplus. In taking such action, the SHPDA would take into consideration the recommendations of the appropriate HSA (including those recommendations embodied in the health systems plan), and the recommendations of the State Commission on Hospital Budgets. After a service or facility was declared surplus, the State Commission on Hospital Budgets would be precluded from approving operating expenses for the service or facility declared surplus. Federal funds would be authorized to pay for the costs of decertification including the costs of retiring long-term debt.

The proposal is based upon the premise that the need and access criteria normally used by SHPDAs are not sufficient for designation of unneeded services and facilities. Instead, it is argued that both those who look mainly at need and access, SHPDAs, and those who look mainly at costs, state budget commissions, should have input into these decisions so that the best trade-off between cost and need could be identified. The cooperative system as proposed would have more options available to it in order to pay the costs of decertification. For example, the costs of decertification (debt retirement, personnel termination, changes in physical plant, provision of alternative modes of care, etc.) could be covered through adjustments by the budget commission to the revenue structure of the institution or institutions involved.

IV. EXPENDITURE AND OTHER FINANCIAL DATA FOR COMMUNITY HOSPITALS

The following tables were prepared by the Department of Health, Education, and Welfare at the request of the staff of the Subcommittee on Health for use in the subcommittee's consideration of H.R. 6575. The tables provide expenditure and other financial data on community hospitals. Community hospitals most clearly represent those hospitals which are affected by the provisions of H.R. 6575. Community hospitals include all non-Federal short-term general and other special hospitals, excluding hospital units of other institutions, whose facilities and services are available to the public. Certain tables also include information on Federal facilities. The tables included in this section are listed below:

Data on Hospital Expenditures

- A-1. Inpatient Community Hospital Expenditures; Historical Trends and Projections with and without the impact of H.R. 6575.
- A-2. Medicare and Medicaid Expenditures for Inpatient Hospital Care: Historical Trends and Projections with and without the Impact of H.R. 6575.
- A-3. Rates of Increase of Community Hospital Expenses per Inpatient Day and per Admission, for Fiscal Years 1968-82.
- A-4. Community Hospital Expense Data for 1975.
- A-5. Payroll, Nonpayroll, and Total Expense per Inpatient Day for Community Hospitals in 1975, and Percentage Increase over 1974.
- A-6. Payroll and Nonpayroll Expense as a Percentage of Total Expense per Inpatient Day for Community Hospitals in 1975 and 1974.
- A-7. Average Annual Percentage Change in Expense per Admission for Community Hospitals in 1975, by Size of Hospital, Geographical Location, and Type of Ownership.
- A-8. Distribution of Community Hospitals by Number of Admissions and Type of Ownership for 1975.
- A-9. Selected Characteristics of U.S. Community Hospitals.

Hospital Utilization Data

- B-1. Occupancy Rates in Community Hospitals by State, 1975.
- B-2. Community Hospital Occupancy Rates (Percent) by Health Service Areas, United States, 1974.
- B-3. Average Annual Percentage Increase in Admissions for Community Hospitals in 1975 by Size of Hospital, Geographical Location, and Type of Ownership.
- B-4. Distribution of Community Hospitals by Percent Change in Admissions for 1975 by Size of Hospital.

Factors in Increasing Hospital Costs

- C-1. Factors Affecting the Increase in Hospital Daily Costs.
 C-2. Factors Affecting Increase in Community Hospital Expense per Patient Day and per Admission.
 C-3. Trends in Payroll and Nonpayroll Expense per Patient Day.
 C-4. Trends in Nonsupervisory Employee Hourly Earnings, Hospitals and All Private Sector Nonagricultural Employees.
 C-5. Wages for Different Occupations in the Hospital Sector for Selected Cities.

Hospital Capital Data

- D-1. Community Hospital Assets per Capita by State, 1975.
 D-2. Community Hospital Beds—Population Ratios by State for 1975.
 D-3. Community Hospital Beds per 1,000 Population by Health Service Areas, United States, 1974.
 D-4. Expected Hospital Capital Expenditures Under the Hospital Cost Containment Act in FY 1981.
 D-5. Capital Spending in Community Hospitals, 1973-75.
 D-6. Average Annual Percentage Change in Assets for Community Hospitals in 1975, by Size of Hospital, Geographical Location, and Type of Ownership.

DATA ON HOSPITAL EXPENDITURES

TABLE A-1.—INPATIENT COMMUNITY HOSPITAL EXPENDITURES: HISTORICAL TRENDS AND PROJECTIONS
 WITH AND WITHOUT THE IMPACT OF H.R. 6575

	Expenditures (billions)	Percent of GNP	Impact of H.R. 6575	Percent of GNP
Fiscal year:				
1967	\$10.6	1.4		
1968	12.4	1.5		
1969	14.6	1.6		
1970	17.2	1.8		
1971	19.6	1.9		
1972	22.3	2.0		
1973	24.7	2.0		
1974	28.0	2.1		
1975	33.0	2.3		
1976	39.2	2.4		
1977 ¹	* 45.6	* 2.5	* 45.6	* 2.5
1978	* 52.3	* 2.6	* 50.4	* 2.5
1979	* 59.7	* 2.6	* 56.1	* 2.5
1980	* 67.8	* 2.7	* 61.4	* 2.4
1981	* 76.5	* 2.8	* 66.9	* 2.4
1982	* 85.5	* 2.9	* 72.9	* 2.5

¹ New fiscal year period begins.

* Projection.

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education, and Welfare.

TABLE A-2.—MEDICARE AND MEDICAID EXPENDITURES FOR INPATIENT HOSPITAL CARE: HISTORICAL TRENDS AND PROJECTIONS WITH AND WITHOUT THE IMPACT OF H.R. 6575

Fiscal year:	Medicare ¹		Medicaid ²	
	Expenditures (billions)	Impact of H.R. 6575	Expenditures (billions)	Impact of H.R. 6575
1967.....	\$2.4			
1968.....	3.4			
1969.....	4.2			
1970.....	4.5		\$1.2	
1971.....	5.2		1.7	
1972.....	5.9		2.2	
1973.....	6.4		2.4	
1974.....	7.5		2.6	
1975.....	9.9		2.9	
1976.....	11.7		3.3	
1977 ³	⁴ 14.5	⁴ 14.5	⁴ 3.8	⁴ 3.8
1978.....	⁴ 17.1	⁴ 16.5	⁴ 4.4	⁴ 4.3
1979.....	⁴ 20.0	⁴ 18.8	⁴ 5.2	⁴ 4.8
1980.....	⁴ 23.2	⁴ 21.5	⁴ 5.8	⁴ 5.4
1981.....	⁴ 26.9	⁴ 24.4	⁴ 6.6	⁴ 6.0
1982.....	⁴ 30.8	⁴ 27.7	⁴ 7.4	⁴ 6.7

¹ Source: Office of the Actuary, Department of Health, Education, and Welfare.² Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education and Welfare.³ New fiscal year period begins.⁴ Projection.

TABLE A-3.—RATES OF INCREASE OF COMMUNITY HOSPITAL EXPENSE PER INPATIENT DAY AND PER ADMISSION, FOR FISCAL YEARS 1968-82

Fiscal year:	Rate of increase of adjusted expense per inpatient day ¹	Rate of increase of adjusted expense per admission ¹
1968.....	12.9	16.5
1969.....	14.6	13.8
1970.....	14.8	12.1
1971.....	13.5	10.4
1972.....	13.3	9.7
1973.....	8.9	8.0
1974.....	10.4	8.2
1975.....	16.1	15.4
1976.....	14.7	14.7
1977 ²	³ 14.8	³ 13.8
1978.....	³ 14.2	³ 13.2
1979.....	³ 13.7	³ 12.7
1980.....	³ 13.3	³ 12.3
1981.....	³ 12.2	³ 11.3
1982.....	³ 11.3	³ 10.4

¹ Percent increase over the preceding period.² New fiscal year period begins.³ Projection, in the absence of any cost containment program.

Source: Health Care Financing Administration, Department of Health, Education, and Welfare.

TABLE A-4.—COMMUNITY HOSPITAL EXPENSE DATA FOR 1975

	Expense per inpatient admission ¹			Expense per inpatient day ¹			
	Amount	State rank	Percent change 1974-75	Amount	State rank	Percent change 1974-75	State rank
All United States.....	1,030.34		16.3	133.81		17.8	
Alabama.....	773.23	38	14.1	105.92	37	15.7	40
Alaska.....	918.24	20	19.8	9	183.65	2	12.6
Arizona.....	1,109.92	11	17.5	17	149.99	11	15.9
Arkansas.....	614.73	50	13.2	48	94.57	48	15.0
California.....	1,225.00	6	17.4	19	185.61	1	19.1
Colorado.....	866.15	28	17.4	18	131.24	17	17.4
Connecticut.....	1,224.82	7	15.4	35	163.31	6	15.4
Delaware.....	1,155.27	9	21.5	2	139.19	15	23.0
District of Columbia.....	1,424.42	3	21.6	1	180.31	3	23.2
Florida.....	1,012.68	16	21.0	5	136.85	16	21.0
Georgia.....	779.67	36	15.2	37	121.82	25	18.8
Hawaii.....	898.44	22	10.2	51	130.21	18	10.2
Idaho.....	648.23	46	12.8	49	102.89	40	16.4
Illinois.....	1,147.50	10	15.6	33	143.44	13	18.5
Indiana.....	886.27	24	19.1	12	112.19	32	17.6
Iowa.....	775.03	37	16.2	31	99.36	44	16.2
Kansas.....	799.42	31	16.2	29	102.49	41	17.8
Kentucky.....	698.16	45	15.3	36	98.33	46	15.3
Louisiana.....	810.41	30	21.0	4	124.68	23	21.0
Maine.....	866.55	27	21.3	3	117.10	27	21.3
Maryland.....	1,276.35	5	16.5	26	153.78	9	17.9
Massachusetts.....	1,496.14	2	15.6	34	176.02	4	15.6
Michigan.....	1,181.46	8	17.7	15	144.08	12	17.7
Minnesota.....	982.26	17	14.4	43	111.62	34	14.4
Mississippi.....	645.99	47	16.5	25	93.62	49	16.5
Missouri.....	957.26	18	16.4	27	116.74	29	19.2
Montana.....	635.41	49	16.6	24	99.28	45	20.3
Nebraska.....	876.08	25	16.1	32	108.16	36	18.9
Nevada.....	1,036.16	14	13.7	45	159.41	8	11.9
New Hampshire.....	792.53	33	17.3	20	111.62	33	17.3
New Jersey.....	1,095.17	12	13.6	46	125.88	20	14.9
New Mexico.....	736.69	43	18.9	13	124.86	21	21.0
New York.....	1,634.16	1	19.1	11	165.07	5	17.9
North Carolina.....	767.40	40	14.5	41	100.97	43	14.5
North Dakota.....	770.92	39	17.1	22	92.88	50	18.5
Ohio.....	1,023.46	15	16.3	30	124.81	22	16.3
Oklahoma.....	789.25	34	19.9	8	117.80	26	19.9
Oregon.....	886.29	23	18.5	14	140.68	14	20.4
Pennsylvania.....	1,056.35	13	16.3	28	124.28	24	19.1
Rhode Island.....	1,292.13	4	15.1	39	161.52	7	20.9
South Carolina.....	742.80	41	19.3	10	101.75	42	17.7
South Dakota.....	644.07	48	13.3	47	92.01	51	18.2
Tennessee.....	781.10	35	17.2	21	104.15	38	17.2
Texas.....	794.36	32	20.2	7	116.82	28	20.2
Utah.....	711.14	44	15.2	38	126.99	19	15.2
Vermont.....	899.48	21	10.3	50	115.32	30	15.9
Virginia.....	873.98	26	17.5	16	109.25	35	19.0
Washington.....	847.48	29	20.3	6	151.34	10	20.3
West Virginia.....	737.68	42	16.7	23	97.06	47	18.3
Wisconsin.....	938.24	19	15.1	40	114.42	31	16.5
Wyoming.....	571.02	51	14.5	42	103.82	39	22.8

¹ Adjusted to reflect the volume of outpatient visits.

Source: "Hospital Statistics," editions for 1975 and 1976, American Hospital Association.

TABLE A-5.—PAYROLL, NONPAYROLL, AND TOTAL EXPENSE PER INPATIENT DAY FOR COMMUNITY HOSPITALS IN 1975, AND PERCENTAGE INCREASE OVER 1974

	Payroll expense per in- patient day	Percent change	Nonpayroll expense per in- patient day	Percent change	Total expense per in- patient day	Percent change
All community hospitals.....	70.93	14.7	62.83	21.6	133.81	17.8
By type of ownership:						
Nonprofit.....	71.34	14.9	62.02	20.7	133.36	17.5
Proprietary.....	57.76	14.1	75.04	23.9	132.80	22.0
Governmental.....	73.62	14.2	62.01	22.2	135.64	17.7
By region:						
New England.....	89.07	14.2	71.72	19.2	160.79	16.4
Mid-Atlantic.....	81.30	14.5	64.20	21.8	145.50	17.6
South Atlantic.....	62.83	13.9	60.24	24.7	123.07	18.9
East north-central.....	71.26	15.2	60.24	20.2	131.49	17.4
East south-central.....	51.11	12.4	50.40	20.3	101.52	16.2
West north-central.....	57.48	15.1	50.56	19.7	108.04	17.2
West south-central.....	58.52	17.1	57.57	22.8	116.08	19.9
Mountain.....	67.17	15.8	63.01	18.6	130.18	17.1
Pacific.....	88.65	14.7	88.21	23.9	176.87	19.1

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education, and Welfare. All figures are derived from the 1975 and 1976 editions of "Hospital Statistics," American Hospital Association.

TABLE A-6.—PAYROLL AND NONPAYROLL EXPENSE AS A PERCENTAGE OF TOTAL EXPENSE PER INPATIENT DAY FOR COMMUNITY HOSPITALS IN 1975 AND 1974

	1975		1974	
	Payroll expense ¹	Nonpayroll expense	Payroll expense ¹	Nonpayroll expense
All community hospitals.....	53.0	47.0	54.5	45.5
By type of ownership:				
Nonprofit.....	53.5	46.5	54.7	45.3
Proprietary.....	43.5	56.5	46.5	53.5
Governmental.....	54.3	45.7	56.0	44.0
By region:				
New England.....	55.4	44.6	56.4	43.6
Mid-Atlantic.....	55.9	44.1	57.4	42.6
South Atlantic.....	51.1	48.9	53.3	46.7
East north-central.....	54.2	45.8	55.2	44.8
East south-central.....	50.3	49.7	52.1	47.9
West north-central.....	53.2	46.8	54.2	45.8
West south-central.....	50.4	49.6	51.6	48.4
Mountain.....	51.6	48.4	52.2	47.8
Pacific.....	50.1	49.9	52.1	47.9

¹ The best available estimates indicate that wages of nonsupervisory employees comprise approximately 75-80 percent of payroll expense.

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education and Welfare. All figures are derived from the 1975 and 1976 editions of "Hospital Statistics," American Hospital Association.

TABLE A-7.—AVERAGE ANNUAL PERCENTAGE CHANGE IN EXPENSE PER ADMISSION FOR COMMUNITY HOSPITALS IN 1975, BY SIZE OF HOSPITAL, GEOGRAPHICAL LOCATION, AND TYPE OF OWNERSHIP¹

[In percent]

	Size grouping		
	All community hospitals	Small (under 4,000 admissions)	Large (over 4,000 admissions)
By geographical location:			
All United States.....	19.4	20.1	18.5
New England.....	20.7	24.0	17.7
Mid-Atlantic.....	19.5	20.2	19.2
South Atlantic.....	19.5	20.6	18.4
East north-central.....	18.1	18.8	17.7
East south-central.....	16.6	16.6	16.6
West north-central.....	18.0	18.3	17.3
West south-central.....	20.1	20.1	20.4
Mountain.....	17.5	17.1	18.2
Pacific.....	23.3	26.0	19.8
By type of ownership:			
Federal.....	13.5	15.3	10.9
Other governmental.....	19.0	19.4	17.8
Voluntary.....	18.4	18.9	18.0
Proprietary.....	24.7	24.8	24.3

¹ Based on American Hospital Association survey data for 1974-75.

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education, and Welfare.

TABLE A-8.—DISTRIBUTION OF COMMUNITY HOSPITALS BY NUMBER OF ADMISSIONS AND TYPE OF OWNERSHIP FOR 1975¹

Type of ownership	Number of admissions							
	0-2,000		2,000-4,000		4,000 plus		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Federal.....	105	4.9	81	5.8	150	5.3	331	5.3
Other governmental.....	939	43.0	434	31.1	496	17.5	1,869	29.2
Voluntary (nonprofit).....	802	36.7	640	45.8	1,946	68.8	3,388	52.8
Proprietary.....	335	15.4	241	17.3	238	8.4	814	12.7
Total.....	2,182	100.0	1,396	100.0	2,830	100.0	6,408	100.0
Percent of total.....	34		22		44		100	

¹ Based on American Hospital Association survey data for 1975.

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education, and Welfare.

TABLE A-9.—SELECTED CHARACTERISTICS OF U.S. COMMUNITY HOSPITALS

Item	Total	Nonprofit	For profit	State and local government
Number:				
Hospitals.....	5,979	3,364	775	1,840
Beds.....	946,976	658,948	73,495	214,533
Admissions (thousands).....	33,519	23,735	2,646	7,138
Patient days (thousands).....	258,457	186,175	17,683	54,599
Outpatient visits (thousands).....	196,311	132,368	7,713	56,230
Average length of stay.....	7.7	7.8	6.6	7.6
Occupancy rates.....	74.8	77.4	65.9	69.7
Personnel ¹	2,398,686	1,713,682	139,395	545,609
Amount (millions):				
Net total revenue ²	\$39,248	\$28,501	(³)	(³)
Net income ²	138	536	(³)	(³)
Total expenses.....	39,110	27,965	\$2,561	\$8,584
Payroll expenses.....	20,749	14,961	1,114	4,674
Total assets.....	47,256	35,827	1,589	8,890
Plant assets.....	31,655	24,005	2,538	6,061

¹ Personnel includes full-time employees and full-time equivalents of part-time employees, but not interns, residents or students.

² Revenue figures exclude hospital units in institutions (104 hospital units comprising 5,132 beds). These units are included in the expense figures and all other data. Therefore, revenue and income are slightly understated.

³ Not available.

Source: Hospital Statistics 1975, American Hospital Association, 1976.

HOSPITAL UTILIZATION DATA

TABLE B-1.—OCCUPANCY RATES IN COMMUNITY HOSPITALS BY STATE, 1975

State	Occupancy rate	State	Occupancy rate
Alabama.....	73.6	Montana.....	62.0
Alaska.....	63.4	Nebraska.....	66.0
Arizona.....	74.0	Nevada.....	68.2
Arkansas.....	73.2	New Hampshire.....	70.9
California.....	66.3	New Jersey.....	81.3
Colorado.....	71.8	New Mexico.....	64.7
Connecticut.....	78.4	New York.....	84.1
Delaware.....	81.8	North Carolina.....	77.9
District of Columbia.....	79.1	North Dakota.....	68.7
Florida.....	72.3	Ohio.....	80.8
Georgia.....	69.8	Oklahoma.....	69.9
Hawaii.....	70.6	Oregon.....	66.1
Idaho.....	68.3	Pennsylvania.....	77.1
Illinois.....	76.4	Rhode Island.....	82.0
Indiana.....	76.9	South Carolina.....	74.1
Iowa.....	68.0	South Dakota.....	63.7
Kansas.....	70.1	Tennessee.....	76.2
Kentucky.....	77.1	Texas.....	70.1
Louisiana.....	70.4	Utah.....	74.8
Maine.....	71.6	Vermont.....	70.7
Maryland.....	80.1	Virginia.....	78.5
Massachusetts.....	78.3	Washington.....	67.5
Michigan.....	79.3	West Virginia.....	75.6
Minnesota.....	70.7	Wisconsin.....	71.6
Mississippi.....	73.7	Wyoming.....	56.1
Missouri.....	76.0		

Source: P. 17-141, "Hospital Statistics, 1976," American Hospital Association.

TABLE B-2.—COMMUNITY HOSPITAL OCCUPANCY RATES (PERCENT) BY HEALTH SERVICE AREAS, UNITED STATES
1974

States	Health service areas													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Alabama.....	66	81	76	71	69	76	67							
Alaska.....	64													
Arizona.....	74	75	59		70									
Arkansas.....	71	69	72	69										
California.....	60	68	65	70	69	66	69	67	64	61	66	66	60	67
Colorado.....	69	71	65											
Connecticut.....	80	81	77	78	66									
Delaware.....	81													
District of Columbia.....	79													
Florida.....	68	62	70	73	68	70	72	67	74					
Georgia.....	72	67	68	73	67	63	73							
Hawaii.....	68													
Idaho.....	68													
Illinois.....	66	68	71	71	65		80	72	78	73	81			
Indiana.....	78	76	74											
Iowa.....	67	71	73											
Kansas.....	64	70	70	78										
Kentucky.....	79	73	85											
Louisiana.....	75	65	66											
Maine.....	71													
Maryland.....	76	86	72	80	80									
Massachusetts.....	75	75	80	82	79									
Michigan.....	82	69	77	75	80	77	76	70						
Minnesota.....	65	74	69	72	72	62	74							
Mississippi.....	71													
Missouri.....	78	69	81	73	73									
Montana.....	61													
Nebraska.....	60	65	71	67										
Nevada.....	65	70												
New Hampshire.....	71													
New Jersey.....	83	79	83	81	81									
New Mexico.....	64													
New York.....	84	84	32	81	84	81	85	86						
North Carolina.....	75	79	78	78	78	75								
North Dakota.....	69	65	69											
Ohio.....	85	84	75	78	80	76	76	84	81	79				
Oklahoma.....	69													
Oregon.....	69	66	59											
Pennsylvania.....	81	82	73	76	70	78	72	81	71					
Rhode Island.....	82													
South Carolina.....	77	73	72	74	73									
South Dakota.....	64													
Tennessee.....	75	74	72	76	66	78								
Texas.....	65	64	67	63	71	64	70	70	70	67	72	61		
Utah.....	74													
Vermont.....	71													
Virginia.....	75	75	79	78	78	75								
Washington.....	70	63	64	67										
West Virginia.....	75													
Wisconsin.....	70	74	71	69	68	72	74							
Wyoming.....	56													

Note: Data base of health service areas as used here differs somewhat from officially designated areas due to data constraints. Community hospitals are defined as non-Federal, short-term general and other special hospitals, excluding hospital units of institutions.

Source: Unpublished data from area resource file, Bureau of Health Manpower.

TABLE B-3.—AVERAGE ANNUAL PERCENTAGE INCREASE IN ADMISSIONS FOR COMMUNITY HOSPITALS IN 1975, BY SIZE OF HOSPITAL, GEOGRAPHICAL LOCATION, AND TYPE OF OWNERSHIP¹

[In percent]

Geographical location	Size grouping		
	All community hospitals	Small (under 4,000 admissions)	Large (over 4,000 admissions)
All United States.....	2.9	4.0	1.4
New England.....	1.5	2.1	.9
Mid-Atlantic.....	2.2	4.4	1.2
South-Atlantic.....	3.9	6.1	1.6
East north-central.....	2.7	4.3	1.4
East south-central.....	2.7	3.3	1.5
West north-central.....	2.0	2.2	1.6
West south-central.....	4.2	5.4	1.4
Mountain.....	2.7	3.0	1.9
Pacific.....	2.7	3.8	1.3
By type of ownership:			
Federal.....	3.5	3.3	3.9
Other governmental.....	2.6	2.9	1.7
Voluntary.....	2.8	4.8	1.3
Proprietary.....	3.7	4.6	1.6

¹ Based on American Hospital Association survey data for 1974-75

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education, and Welfare

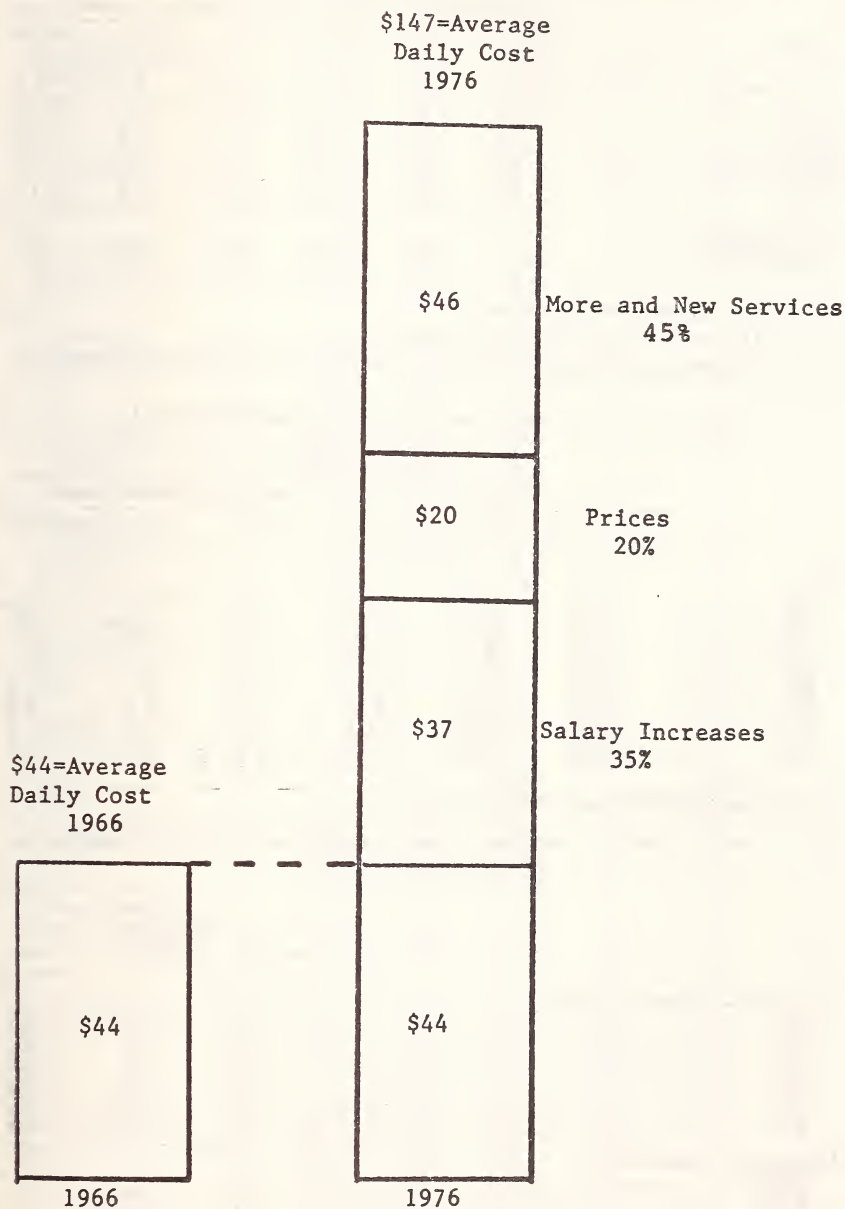
TABLE B-4.—DISTRIBUTION OF COMMUNITY HOSPITALS BY PERCENT CHANGE IN ADMISSIONS FOR 1975 BY SIZE OF HOSPITAL¹

	Percent of hospitals within range	Number of hospitals within range
SMALL HOSPITALS (UNDER 4,000 ADMISSIONS)		
Percent change in admissions: ²		
Less than -15.....	9.3	309
-15 to -10.....	6.5	216
-10 to +2.....	42.6	1,405
+2 to +15.....	27.9	919
Greater than +15.....	13.7	455
Total.....	100.0	3,304
LARGE HOSPITALS (OVER 4,000 ADMISSIONS)		
Percent change in admissions: ²		
Less than -15.....	2.5	64
-15 to -6.....	8.1	209
-6 to +2.....	46.8	1,206
+2 to +15.....	38.1	983
Greater than +15.....	4.5	116
Total.....	100.0	2,578

¹ Based on American Hospital Association survey data. Total sample, 5,882 hospitals.² The ranges shown are in accordance with the specifications of the admission load formula in sec. 113 of H.R. 6575.

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education, and Welfare.

FACTORS IN INCREASING HOSPITAL COSTS

TABLE C-1.—*Factors affecting the increase in hospital daily costs*

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department, Health, Education and Welfare.

Note that the average daily cost of a hospital stay would have doubled during this period even if wages and prices had remained constant.

TABLE C-2.—FACTORS AFFECTING INCREASE IN COMMUNITY HOSPITAL EXPENSE PER PATIENT DAY AND PER ADMISSION

Factor	Average annual percentage change					
	Expense per inpatient day ¹			Expense per admission ¹		
	1965-71	1971-74	1974-76	1965-71	1971-74	1974-76
Total increase	13.0	10.2	15.2	13.3	8.6	15.1
Increase in wages and prices	6.7	5.9	9.5	6.7	5.8	9.5
Wages	8.1	6.0	9.4	8.1	6.0	9.4
Prices	4.1	5.5	9.0	4.1	5.5	9.0
Changes in services	6.3	4.3	5.7	6.6	2.8	5.6
Labor	3.6	1.7	2.4	3.9	.2	2.3
Other	9.9	7.6	9.1	10.2	6.0	8.9
Percent of total increase due to:						
Wages and prices	51.4	57.3	62.2	50.3	67.4	62.9
Changes in services	48.6	42.7	37.8	49.7	32.6	37.1

¹ Adjusted to exclude expenses for outpatient care.

Note.—Data for community hospitals includes units of institutions.

Source: Price data are from Consumer Price Index, Bureau of Labor Statistics, all other data from Hospital Indicators various years, American Hospital Association.

TABLE C-3.—TRENDS IN PAYROLL AND NONPAYROLL EXPENSE PER PATIENT DAY

Year:	Expense per patient day					
	Amount			Average annual percentage increase		
	Total	Payroll	Nonpayroll	Total	Payroll	Nonpayroll
1950	\$15.62	\$8.86	\$6.76	-----	-----	-----
1955	23.12	14.26	8.86	8.2	10.0	5.6
1960	32.23	20.08	12.15	6.9	7.1	6.5
1965	44.48	27.44	17.04	6.7	6.4	7.0
1967	54.08	32.44	21.64	10.3	8.7	12.7
1969	70.03	41.36	28.67	13.8	12.9	15.1
1970	81.01	47.30	33.71	15.7	14.4	17.6
1971	92.31	53.80	38.51	13.9	13.7	14.2
1972	105.21	59.79	45.42	14.0	11.1	17.9
1973	114.69	63.86	50.83	9.0	6.8	11.9
1974	128.05	69.83	58.22	11.6	9.3	14.5
1975	151.42	80.34	71.08	18.3	15.1	22.1

Source: Hospital Statistics 1975, American Hospital Association 1976.

TABLE C-4.—TRENDS IN NONSUPERVISORY EMPLOYEE HOURLY EARNINGS, HOSPITALS AND ALL PRIVATE SECTOR NONAGRICULTURAL EMPLOYEES

	Hospitals	Private sector non-agricultural industry	Ratio
Hourly earnings—nonsupervisory employees:			
1969	\$2.57	\$3.04	84.5
1970	2.79	3.22	86.6
1971	2.96	3.44	86.0
1972	3.08	3.67	83.9
1973	3.22	3.92	82.1
1974	3.45	4.22	81.8
1975	3.83	4.54	84.4
1976	4.18	4.87	85.8
Annual rates of increase (percent):			
1969-70	8.6	5.9	-----
1970-71	6.1	6.8	-----
1971-72	4.1	6.7	-----
1972-73	4.5	6.8	-----
1973-74	7.1	7.7	-----
1974-75	11.0	7.6	-----
1975-76	9.1	7.3	-----
Average 1969-76	7.2	7.0	-----

Source: Bureau of Labor Statistics, Employment and Earnings, March 1977.

TABLE C-5.—WAGES FOR DIFFERENT OCCUPATIONS IN THE HOSPITAL SECTOR FOR SELECTED CITIES

	Wages—weekly			Average annual percentage increase		
	1969	1972	1975	1969-72	1972-75	1969-75
Atlanta:						
Registered nurses.....	\$134.50	\$171.50	\$194.00	8.4	4.2	6.3
Licensed practical nurses.....	96.50	121.50	142.50	8.0	5.5	6.7
Nurse's aides.....	71.00	94.00	110.00	9.8	5.4	7.6
Maids.....	62.50	89.00	104.50	12.6	5.4	9.0
Porters.....	68.00	91.00	104.00	10.1	4.6	7.3
Baltimore:						
Registered nurses.....	143.50	188.50	234.00	9.5	7.5	8.5
Licensed practical nurses.....	109.00	156.50	191.00	12.8	6.9	9.8
Nurse's aides.....	77.00	119.50	154.50	15.8	8.9	12.3
Maids.....	73.00	115.50	144.50	16.7	7.7	12.1
Porters.....	74.00	107.50	142.00	13.3	9.7	11.5
Boston:						
Registered nurses.....	152.00	185.00	222.50	6.8	6.3	6.6
Licensed practical nurses.....	126.50	149.50	177.00	5.7	5.8	5.8
Nurse's aides.....	97.50	114.50	141.00	5.5	7.2	6.3
Maids.....	90.00	108.00	134.50	6.3	7.6	6.9
Porters.....	94.00	112.00	137.00	6.0	7.0	6.5
Buffalo:						
Registered nurses.....	137.00	163.50	198.50	6.1	6.7	6.4
Licensed practical nurses.....	99.00	121.50	153.00	7.1	8.0	7.5
Nurse's aides.....	76.50	99.50	124.50	9.2	7.8	8.5
Maids.....	82.50	103.00	121.00	7.8	5.4	6.6
Porters.....	97.00	110.00	129.50	4.4	5.6	5.0
Chicago:						
Registered nurses.....	148.50	186.00	229.00	7.8	7.2	7.5
Licensed practical nurses.....	112.50	147.50	185.00	9.4	7.8	8.6
Nurse's aides.....	85.00	119.50	147.50	12.0	7.3	8.6
Maids.....	82.00	115.50	147.50	12.1	8.5	10.3
Porters.....	90.50	125.50	153.00	11.6	6.8	9.1
Dallas:						
Registered nurses.....	135.00	165.00	196.00	6.9	5.9	6.4
Licensed practical nurses.....	92.00	110.00	142.00	6.1	8.9	7.5
Nurse's aides.....	65.50	86.50	107.00	9.7	7.3	8.5
Maids.....	63.50	82.00	102.00	8.8	7.5	8.2
Porters.....	71.00	84.50	105.50	6.0	7.8	6.9
Denver:						
Registered nurses.....	142.50	170.50	217.00	6.2	8.4	7.3
Licensed practical nurses.....	96.50	115.50	148.00	6.2	8.6	7.4
Nurse's aides.....	78.00	95.00	123.50	6.8	9.1	8.0
Maids.....	71.50	93.00	121.00	9.0	9.2	9.1
Porters.....	77.00	101.00	124.50	9.3	7.1	8.2
Detroit:						
Registered nurses.....	158.00	197.50	238.50	7.7	6.5	7.1
Licensed practical nurses.....	121.00	157.50	193.00	9.2	7.0	8.1
Nurse's aides.....	88.50	117.00	146.00	9.8	7.7	8.7
Maids.....	81.50	113.50	140.50	11.7	7.3	9.5
Porters.....	95.50	125.00	152.50	9.3	6.9	8.1
Los Angeles:						
Registered nurses.....	160.00	199.00	250.50	7.5	8.0	7.8
Licensed practical nurses.....	117.50	149.00	187.00	8.2	7.9	8.1
Nurse's aides.....	90.50	117.00	143.00	8.9	6.9	7.9
Maids.....	85.00	110.00	139.50	9.1	8.3	8.7
Porters.....	93.00	119.00	150.00	8.4	8.1	8.3
Memphis:						
Registered nurses.....	142.00	167.00	205.00	5.6	7.1	6.3
Licensed practical nurses.....	98.50	124.00	160.00	8.0	8.9	8.4
Nurse's aides.....	69.50	95.50	119.50	11.2	7.8	9.5
Maids.....	66.00	192.50	113.00	11.9	6.9	9.3
Porters.....	67.00	90.50	110.00	10.4	6.8	8.6
Miami:						
Registered nurses.....	143.00	180.00	214.50	8.0	6.0	7.0
Licensed practical nurses.....	98.50	126.50	157.00	8.7	7.5	8.1
Nurse's aides.....	70.50	94.00	116.00	10.1	7.3	8.7
Maids.....	65.50	88.00	110.00	10.3	7.7	9.0
Porters.....	69.00	89.00	109.00	9.0	7.0	8.0
Minneapolis:						
Registered nurses.....	146.00	180.00	223.50	7.2	7.5	7.4
Licensed practical nurses.....	100.50	132.00	164.00	9.5	7.5	8.5
Nurse's aides.....	82.00	108.00	131.00	9.6	6.6	8.1
Maids.....	86.00	108.50	135.50	8.0	7.7	7.9
Porters.....	101.50	117.50	144.00	5.0	7.0	6.0
New York:						
Registered nurses.....	163.50	211.00	268.50	8.9	8.4	8.6
Licensed practical nurses.....	122.00	157.00	215.00	8.8	11.0	9.9
Nurse's aides.....	100.50	137.50	182.00	11.0	9.8	10.4
Maids.....	99.50	138.50	201.00	11.6	13.2	12.4
Porters.....	99.00	136.50	201.00	11.3	13.8	12.5

See footnotes at end of table.

TABLE C-5.—WAGES FOR DIFFERENT OCCUPATIONS IN THE HOSPITAL SECTOR FOR SELECTED CITIES—Continued

	Wages—weekly			Average annual percentage increase		
	1969	1972	1975	1969-72	1972-75	1969-75
Philadelphia:						
Registered nurses.....	\$135.50	\$172.50	\$213.50	8.4	7.4	7.9
Licensed practical nurses.....	96.00	134.50	171.00	11.9	8.3	10.1
Nurse's aides.....	74.00	110.50	147.00	14.3	10.0	12.1
Maids.....	73.00	105.00	145.00	12.8	11.2	12.0
Porters.....	75.50	109.00	147.00	12.9	10.6	11.7
Portland, Oreg.:						
Registered nurses.....	144.50	175.00	242.00	6.6	11.4	9.0
Licensed practical nurses.....	103.00	135.50	172.00	9.6	8.3	8.9
Nurse's aides.....	77.50	108.00	145.00	11.7	10.3	11.0
Maids.....	72.00	91.50	115.50	9.4	11.1	10.3
Porters.....	75.50	99.00	117.50	10.5	9.8	10.1
St. Louis:						
Registered nurses.....	144.50	173.00	205.00	6.2	5.8	6.0
Licensed practical nurses.....	102.00	128.00	159.50	7.9	7.6	7.7
Nurse's aides.....	75.50	96.00	122.00	8.3	8.3	8.3
Maids.....	72.00	91.50	115.50	8.4	8.1	8.2
Porters.....	75.50	97.00	117.50	8.6	6.7	7.6
San Francisco:						
Registered nurses.....	169.00	214.00	218.00	8.2	9.5	8.8
Licensed practical nurses.....	122.50	164.50	209.50	10.3	8.4	9.4
Nurse's aides.....	109.00	147.00	196.00	10.5	10.1	10.3
Maids.....	101.00	137.50	183.50	10.8	10.1	10.4
Porters.....	111.00	144.00	189.00	9.1	9.5	9.3
Washington, D.C.:						
Registered nurses.....	154.50	182.50	222.50	5.7	6.8	6.3
Licensed practical nurses.....	111.00	139.50	173.00	7.9	7.4	7.7
Nurse's aides.....	75.50	111.00	141.50	11.8	8.4	10.1
Maids.....	80.00	111.50	144.80	11.7	9.1	10.4
Porters.....	89.20	115.60	146.50	9.0	8.2	8.6

Source: Industry Wage Survey: Hospitals, Bureau of Labor Statistics.

HOSPITAL CAPITAL DATA

TABLE D-1.—COMMUNITY HOSPITAL ASSETS PER CAPITA BY STATE, 1975

Region/State	Population (thousands)	Plant assets (thousands)	Total assets (thousands)	Plant assets per capita	Total assets per capita
New England.....	12, 198	\$2, 150, 262	\$3, 626, 421	\$176. 28	\$297. 30
Connecticut.....	3, 095	553, 907	880, 566	178. 97	284. 51
Maine.....	1, 059	143, 092	247, 303	135. 12	233. 53
Massachusetts.....	5, 828	1, 126, 538	1, 905, 957	193. 30	327. 03
New Hampshire.....	818	108, 210	174, 408	132. 29	213. 21
Rhode Island.....	927	137, 999	291, 058	148. 87	313. 98
Vermont.....	471	80, 516	127, 129	170. 94	269. 91
Mid-Atlantic.....	37, 263	6, 118, 356	9, 436, 005	164. 19	253. 23
New Jersey.....	7, 322	962, 028	1, 409, 960	131. 39	192. 56
New York.....	18, 101	3, 343, 196	5, 198, 485	184. 70	287. 19
Pennsylvania.....	11, 841	1, 813, 132	2, 827, 560	153. 12	238. 79
East north-central.....	40, 902	6, 577, 411	9, 523, 572	160. 81	232. 84
Illinois.....	11, 160	2, 024, 506	2, 993, 660	181. 41	268. 25
Indiana.....	5, 313	711, 054	998, 497	133. 83	187. 93
Michigan.....	9, 117	1, 397, 988	1, 979, 246	153. 33	217. 09
Ohio.....	10, 745	1, 710, 059	2, 560, 698	159. 15	238. 32
Wisconsin.....	4, 566	733, 804	991, 471	160. 71	217. 14
West north-central.....	16, 657	2, 801, 143	4, 038, 039	158. 17	242. 42
Iowa.....	2, 857	435, 539	605, 731	152. 45	212. 02
Kansas.....	2, 266	409, 508	582, 987	180. 72	261. 69
Minnesota.....	3, 905	603, 596	869, 963	154. 57	222. 78
Missouri.....	4, 763	840, 582	1, 240, 634	176. 48	260. 47
Nebraska.....	1, 541	288, 498	423, 860	187. 21	275. 06
North Dakota.....	636	132, 532	166, 517	208. 38	261. 82
South Dakota.....	681	90, 888	138, 347	133. 46	203. 15
South Atlantic.....	33, 208	4, 302, 452	6, 429, 909	129. 56	193. 62
Delaware.....	577	89, 571	166, 237	155. 24	288. 11
District of Columbia.....	721	190, 827	284, 526	264. 67	394. 63
Florida.....	8, 099	1, 305, 469	1, 874, 705	161. 19	231. 47
Georgia.....	4, 877	566, 523	932, 685	136. 66	191. 24
Maryland.....	4, 089	454, 275	742, 963	111. 10	181. 70
North Carolina.....	5, 375	539, 785	843, 054	100. 43	156. 85
South Carolina.....	2, 775	251, 505	351, 647	90. 63	126. 72
Virginia.....	4, 910	519, 537	802, 623	105. 81	163. 47
West Virginia.....	1, 784	284, 960	431, 469	159. 73	241. 85
East south-central.....	13, 412	1, 733, 919	2, 524, 516	129. 28	188. 23
Alabama.....	3, 575	526, 403	764, 890	147. 25	213. 96
Kentucky.....	3, 354	363, 298	523, 032	108. 32	155. 94
Mississippi.....	2, 334	262, 174	367, 408	122. 33	157. 42
Tennessee.....	4, 149	582, 044	869, 186	140. 28	209. 49
West south-central.....	20, 529	2, 869, 753	4, 159, 960	139. 78	202. 64
Arkansas.....	2, 068	266, 129	393, 506	128. 69	190. 28
Louisiana.....	3, 762	493, 008	681, 349	131. 05	181. 11
Oklahoma.....	2, 681	505, 605	674, 620	188. 59	251. 63
Texas.....	12, 017	1, 605, 011	2, 410, 491	133. 56	200. 59
Mountain.....	9, 440	1, 106, 332	1, 604, 827	117. 20	170. 02
Arizona.....	2, 160	291, 471	426, 561	134. 94	197. 48
Colorado.....	2, 515	325, 404	456, 248	129. 38	181. 41
Idaho.....	796	79, 285	114, 649	99. 60	144. 03
Montana.....	737	95, 572	129, 332	128. 68	175. 48
Nevada.....	574	79, 488	130, 235	138. 48	226. 89
New Mexico.....	1, 119	101, 564	148, 812	90. 76	132. 99
Wyoming.....	362	37, 665	65, 930	104. 05	182. 13
Utah.....	1, 179	95, 883	133, 060	81. 33	112. 86
Pacific.....	27, 821	3, 995, 264	5, 912, 273	143. 61	212. 51
Alaska.....	341	60, 875	74, 678	178. 52	219. 00
California.....	20, 876	3, 064, 957	4, 552, 105	146. 82	218. 05
Hawaii.....	854	90, 815	154, 553	106. 34	180. 98
Oregon.....	2, 255	299, 057	429, 327	132. 62	190. 39
Washington.....	3, 494	479, 560	701, 610	137. 25	200. 80

Sources: P. 394, Statistical Abstract of the United States, 1976, U.S. Department of Commerce, Bureau of the Census.
P. 17-141, Hospital Statistics, 1976, American Hospital Association.

TABLE D-2.—COMMUNITY HOSPITAL BEDS—POPULATION RATIOS BY STATE FOR 1975

Region/State	Population (thousands)	Beds	Beds per 1,000
New England.....	12, 198		
Connecticut.....	3, 095	10, 857	3.5
Maine.....	1, 059	4, 827	4.6
Massachusetts.....	5, 828	26, 734	4.6
New Hampshire.....	818	3, 393	4.1
Rhode Island.....	927	3, 490	3.8
Vermont.....	471	2, 284	4.8
Mid-Atlantic.....	37, 263		
New Jersey.....	7, 322	29, 721	4.0
New York.....	18, 101	85, 693	7.7
Pennsylvania.....	11, 841	55, 109	4.7
East north-central.....	40, 902		
Illinois.....	11, 160	54, 580	4.9
Indiana.....	5, 313	23, 324	4.4
Michigan.....	9, 117	39, 164	4.3
Ohio.....	10, 745	48, 778	4.5
Wisconsin.....	4, 566	23, 617	5.2
West north-central.....	16, 657		
Iowa.....	2, 857	16, 840	5.9
Kansas.....	2, 266	12, 759	5.6
Minnesota.....	3, 905	23, 650	6.1
Missouri.....	4, 763	25, 491	5.4
Nebraska.....	1, 541	9, 297	6.0
North Dakota.....	636	4, 252	6.7
South Dakota.....	681	3, 717	5.5
South Atlantic.....	53, 208		
Delaware.....	577	2, 002	3.5
District of Columbia.....	721	4, 948	6.9
Florida.....	8, 099	38, 108	4.7
Georgia.....	4, 877	20, 166	4.1
Maryland.....	4, 089	12, 987	3.2
North Carolina.....	5, 375	21, 378	4.0
South Carolina.....	2, 775	10, 751	3.9
Virginia.....	4, 910	19, 091	3.9
West Virginia.....	1, 784	10, 176	5.7
East south-central.....	13, 412		
Alabama.....	3, 575	17, 321	4.8
Kentucky.....	3, 354	14, 435	4.3
Mississippi.....	2, 334	10, 508	4.5
Tennessee.....	4, 149	20, 983	5.1
West south-central.....	20, 529		
Arkansas.....	2, 068	9, 312	4.5
Louisiana.....	3, 762	16, 864	4.5
Oklahoma.....	2, 681	11, 844	4.4
Texas.....	12, 017	55, 139	4.6
Mountain.....	9, 440		
Arizona.....	2, 160	8, 123	3.8
Colorado.....	2, 515	10, 480	4.2
Idaho.....	796	3, 156	4.0
Montana.....	737	3, 807	5.2
Nevada.....	574	2, 428	4.2
New Mexico.....	1, 119	3, 634	3.2
Wyoming.....	362	1, 675	4.6
Utah.....	1, 179	3, 691	3.1
Pacific.....	27, 821		
Alaska.....	341	744	2.2
California.....	20, 876	82, 550	4.0
Hawaii.....	854	2, 456	2.9
Oregon.....	2, 255	8, 802	3.9
Washington.....	3, 494	11, 840	3.4

Sources: p. 394, Statistical Abstract of the United States, 1976, U.S. Dept. of Commerce, Bureau of the Census. Pp. 17-141, Hospital Statistics, 1976, American Hospital Association.

TABLE D-3.—COMMUNITY HOSPITAL BEDS PER 1,000 POPULATION BY HEALTH SERVICE AREAS, UNITED STATES, 1975

States	Health service areas													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Alabama	5.2	3.7	6.1	4.5	4.3	4.5	4.4							
Alaska	1.8													
Arizona	4.0	4.1	2.5		2.7									
Arkansas	5.4	3.6	5.7	4.2										
California	4.4	3.2	3.0	5.0	3.4	3.9	3.0	4.0	3.5	3.9	4.5	4.0	3.9	3.2
Colorado	4.3	4.5	4.3											
Connecticut	3.5	3.9	2.7	3.6	2.9									
Delaware	3.5													
District of Columbia	6.9													
Florida	4.1	4.7	4.6	4.7	5.0	5.4	3.9	5.4	5.8					
Georgia	4.7	3.8	4.3	4.1	4.4	4.7	5.0							
Hawaii	3.1													
Idaho	3.9													
Illinois	3.9	5.8	6.0	4.8	5.5		5.0	4.2	3.4	5.1	5.6			
Indiana	4.1	4.6	4.6											
Iowa	6.1	7.1	5.1											
Kansas	7.9	4.4	6.4	5.1										
Kentucky	4.6	4.2	4.3											
Louisiana	4.6	4.3	5.0											
Maine	4.7													
Maryland	4.0	2.2	1.2	4.1	3.5									
Massachusetts	4.7	4.9	3.9	6.4	3.2									
Michigan	4.4	3.4	4.6	3.9	4.9	4.2	5.9	5.1						
Minnesota	6.7	7.8	5.5	4.8	5.5	5.7	7.7							
Mississippi	4.9													
Missouri	5.1	5.2	5.6	4.9	4.6									
Montana	5.3													
Nebraska	5.3	5.5	7.1	6.1										
Nevada	5.1	3.8												
New Hampshire	4.1													
New Jersey	3.9	5.0	4.1	3.4	3.6									
New Mexico	3.4													
New York	5.1	4.0	4.1	4.8	4.8	4.0	5.6	3.2						
North Carolina	4.3	3.9	4.2	4.9	3.7	3.3								
North Dakota	7.5	6.7	5.5											
Ohio	4.3	3.8	4.2	4.8	4.6	4.7	4.4	4.1	5.0	4.8				
Oklahoma	4.6													
Oregon	4.6	3.0	4.7											
Pennsylvania	4.7	4.0	4.8	4.0	4.9	5.0	5.5	4.8	5.6					
Rhode Island	3.7													
South Carolina	4.2	4.0	3.9	3.5	4.1									
South Dakota	5.5													
Tennessee	4.9	5.4	4.7	5.1	5.0	6.3								
Texas	5.5	5.6	4.5	5.6	4.5	3.8	5.0	3.6	4.0	4.9	5.5	4.5		
Utah	3.2													
Vermont	4.9													
Virginia	4.6	2.6	4.6	5.0	3.6	4.9								
Washington	3.2	2.9	3.7	4.6										
West Virginia	5.8													
Wisconsin	5.3	4.6	5.1	5.2	6.6	5.4	7.8							
Wyoming	4.7													

Note.—Data base of health service areas as used here differs somewhat from officially designated areas due to data constraints. Community hospitals are defined as nonfederal, short-term general, general, and other special hospitals, excluding hospital units of institutions.

Source: Unpublished data from area resource file, Bureau of Health Manpower.

TABLE D-4.—EXPECTED HOSPITAL CAPITAL EXPENDITURES UNDER THE HOSPITAL COST CONTAINMENT ACT
IN FISCAL YEAR 1981¹

[In millions of dollars]

	Capital spending subject to approval by certificate of need and sec. 1122 agencies	Total capital spending
United States.....	2,500.0	4,300.0
Geographic divisions:		
New England.....	142.7	245.5
Connecticut.....	36.2	62.3
Maine.....	12.4	21.3
Massachusetts.....	68.2	117.3
New Hampshire.....	9.6	16.5
Rhode Island.....	10.8	18.6
Vermont.....	5.5	9.5
Middle Atlantic.....	436.1	750.0
New Jersey.....	85.6	147.2
New York.....	212.1	364.8
Pennsylvania.....	138.4	238.0
East North-central.....	479.6	824.9
Illinois.....	130.4	224.3
Indiana.....	62.2	107.0
Michigan.....	107.2	184.4
Ohio.....	125.9	216.5
Wisconsin.....	53.9	92.7
West north-central.....	195.2	335.7
Iowa.....	33.6	57.8
Kansas.....	26.5	45.6
Minnesota.....	45.9	78.9
Missouri.....	55.7	95.8
Nebraska.....	18.1	31.1
North Dakota.....	7.4	12.7
South Dakota.....	8.0	13.8
South Atlantic.....	394.7	678.8
Delaware.....	6.8	11.7
District of Columbia.....	8.4	14.4
Florida.....	97.8	168.2
Georgia.....	57.7	99.2
Maryland.....	48.0	82.6
North Carolina.....	63.8	109.7
South Carolina.....	33.0	56.8
Virginia.....	58.1	99.9
West Virginia.....	21.1	36.3
East south-central.....	158.5	272.7
Alabama.....	42.3	72.8
Kentucky.....	39.7	68.3
Mississippi.....	27.5	47.3
Tennessee.....	49.0	84.3
West south-central.....	234.1	402.7
Arkansas.....	24.8	42.7
Louisiana.....	44.4	76.4
Oklahoma.....	21.7	37.3
Texas.....	143.2	246.3
Mountain.....	112.9	194.2
Arizona.....	26.0	44.7
Colorado.....	29.7	51.1
Idaho.....	9.6	16.5
Montana.....	8.8	15.1
Nevada.....	6.9	11.9
New Mexico.....	13.4	23.0
Utah.....	14.1	24.3
Wyoming.....	4.4	7.6
Pacific.....	330.4	568.4
Alaska.....	4.1	7.1
California.....	247.9	426.4
Hawaii.....	10.1	17.4
Oregon.....	26.8	46.1
Washington.....	41.5	71.4

¹ 1st fiscal year in which all large capital expenditures actually occurring would be subject to title II; i.e., there would be no carryover of projects approved before the act became effective. Table calculated according to the assumption that the ratio of total capital spending to capital spending subject to approval for each region and individual State is the same as for the entire United States.

Source: Health Care Financing Administration, Department of Health, Education, and Welfare.

TABLE D-5.—CAPITAL SPENDING IN COMMUNITY HOSPITALS, 1973-75

[In millions]

	1973	1974	1975
United States.....	\$3,899.6	\$4,361.7	\$5,178.2
GEOGRAPHIC DIVISIONS			
New England.....	258.1	215.0	338.1
Connecticut.....	31.1	45.0	110.7
Maine.....	23.0	33.4	24.1
Massachusetts.....	172.7	103.8	166.1
New Hampshire.....	5.9	19.1	10.6
Rhode Island.....	2.0	9.0	17.4
Vermont.....	23.4	4.7	9.2
Middle Atlantic.....	852.9	682.0	1,004.2
New Jersey.....	162.3	119.1	146.6
New York.....	391.7	396.2	583.7
Pennsylvania.....	298.9	166.7	268.9
East north-central.....	714.1	962.5	1,102.8
Illinois.....	228.7	311.2	340.4
Indiana.....	66.8	131.2	60.3
Michigan.....	158.0	234.6	285.0
Ohio.....	162.4	198.5	311.0
Wisconsin.....	98.2	87.0	106.1
West north-central.....	280.7	433.5	527.1
Iowa.....	47.9	59.2	57.2
Kansas.....	27.4	117.8	60.6
Minnesota.....	41.9	76.4	84.6
Missouri.....	102.7	117.2	212.3
Nebraska.....	29.2	41.7	52.1
North Dakota.....	22.1	9.5	45.8
South Dakota.....	9.5	11.7	14.6
South Atlantic.....	606.9	587.8	705.0
Delaware.....	13.1	2.0	21.1
District of Columbia.....	(12.9)	9.7	62.1
Florida.....	202.3	245.1	227.3
Georgia.....	88.2	91.5	137.3
Maryland.....	73.7	49.8	28.0
North Carolina.....	76.1	64.5	51.2
South Carolina.....	74.6	19.5	23.0
Virginia.....	44.4	65.2	104.8
West Virginia.....	47.4	40.5	50.2
East south-central.....	308.7	174.9	250.9
Alabama.....	95.2	59.3	87.7
Kentucky.....	83.8	20.1	36.9
Mississippi.....	40.6	32.2	43.9
Tennessee.....	89.1	63.3	82.4
West south-central.....	286.4	482.0	514.2
Arkansas.....	35.8	45.8	34.0
Louisiana.....	24.3	63.5	100.9
Oklahoma.....	21.1	79.0	170.8
Texas.....	205.2	293.7	208.5
Mountain.....	108.9	120.3	183.6
Arizona.....	46.1	33.4	42.5
Colorado.....	23.7	49.3	65.6
Idaho.....	4.1	6.6	9.7
Montana.....	1.9	9.7	24.9
Nevada.....	15.3	7.1	8.7
New Mexico.....	9.6	8.3	15.8
Utah.....	7.0	7.1	9.6
Wyoming.....	1.2	(1.2)	6.8
Pacific.....	482.3	703.5	552.1
Alaska.....	4.4	3.6	34.8
California.....	389.9	590.8	364.9
Hawaii.....	.1	16.4	14.8
Oregon.....	46.0	46.3	48.8
Washington.....	41.9	46.4	88.8

Source: Health Care Financing Administration, Department of Health, Education, and Welfare.

TABLE D-6.—AVERAGE ANNUAL PERCENTAGE CHANGE IN ASSETS FOR COMMUNITY HOSPITALS IN 1975,
BY SIZE OF HOSPITAL, GEOGRAPHICAL LOCATION, AND TYPE OF OWNERSHIP¹

Geographical location	Size grouping		
	All community hospitals	Small (under 4,000 admissions)	Large (over 4,000 admissions)
All United States	17.1	17.5	16.7
New England.....	15.5	22.1	9.6
Mid-Atlantic.....	17.2	14.5	18.4
South Atlantic.....	19.9	24.8	14.8
East north-central.....	14.8	16.5	13.5
East south-central.....	10.6	17.8	15.4
West north-central.....	19.6	16.6	28.5
West south-central.....	20.8	21.0	20.4
Mountain.....	14.7	12.8	18.9
Pacific.....	16.4	17.7	14.7
By type of ownership:			
Federal.....	5.3	4.7	6.2
Other governmental.....	15.4	14.9	16.7
Voluntary.....	18.6	19.4	17.3
Proprietary.....	16.7	19.1	10.9

¹ Based on American Hospital Association survey data for 1974-75.

Source: Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education and Welfare.

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

CMS LIBRARY



3 8095 00007214 6